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ABSTRACT

In this budget overview, the Secretary of the Department of Health, Education and Welfare, Caspar W. Weinberger and his assistants present testimony and exhibits on the Department's programs. A large portion of the volume pertains to Public Health Service and Social Security Administration matters. Education issues discussed include bilingual education programs, student loan programs, Basic Educational Opportunity Grants, and impact area aid. Juvenile delinquent programs are also discussed. (JF)

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DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE APPROPRIATIONS FOR 1975

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE
COMMITTEE ON APPROPRIATIONS
HOUSE OF REPRESENTATIVES
NINETY-THIRD CONGRESS

SECOND SESSION

SUBCOMMITTEE ON DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE APPROPRIATIONS

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PART 2

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE:

Overview of Fiscal Year 1975 Budget
Testimony of the Secretary
Special Reports

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DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE APPROPRIATIONS FOR FISCAL YEAR 1975

MONDAY, MARCH 18, 1974.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

OVERVIEW OF THE 1975 BUDGET

WITNESSES

JOHN D. YOUNG, ASSISTANT SECRETARY, COMPTROLLER
CHARLES MILLER, DEPUTY ASSISTANT SECRETARY, BUDGET
WILFORD FORBUSH, DIRECTOR, DIVISION OF BUDGET FORMULATION
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JAMES MORAN, BUDGET ANALYST, SOCIAL AND REHABILITATION SERVICES AND HUMAN DEVELOPMENT PROGRAMS
JOSEPH COOK, BUDGET ANALYST, METHODS AND PRESENTATION BRANCH

Mr. FLOOD. The committee will come to order. We have what we call the overview of the 1975 budget for HEW.

The presentation will be made by John D. Young, Assistant Secretary, Comptroller, Department of Health, Education, and Welfare. We have a biographical sketch we will place in the record at this point.

[The biographical sketch follows:]

BIOGRAPHICAL SKETCH OF JOHN D. YOUNG

Name: John D. Young.

Position: Assistant Secretary, Comptroller, Department of Health, Education and Welfare.

Birthplace and date: Cortland, N.Y., February 5, 1919.

Education: Colgate University, 1941, A.B., Syracuse University, 1943, M.S.

Experience: 1966–73: Deputy Associate Director, Energy and Science Division and Director and Chief, Economics, Science and Technology Division, Office of Management and Budget: 1960–66: Assistant Administrator for Administration and Deputy Director of Administration, National Aeronautics and Space Administration; 1954–60: Principal, McKinsey & Co.; 1951–54: Executive Officer and Executive Secretary, Office of Defense Mobilization.

Other experience: 1953: Staff member, President's Advisory Committee on Governmental Organization; 1953: Assistant to the Chairman, Committee on Reorganization of Department of Defense: 1961: Adviser on organization of Peace Corps; 1965: Member, President's Task Force on Cost Reduction.

Awards: William A. Jump Memorial Award for Outstanding Public Service; NASA Medal for Outstanding Leadership; OMB Exceptional Service Award.

Mr. Flood. We have your HEW budget in brief. How do you wish to proceed, Mr. Young? I don't see your charts. I guess that is because of the aura of the new stage setting we are in here. How do you wish to proceed?

Mr. Young. Mr. Chairman, in the past two very distinguished public servants, Jim Kelly and Bruce Cardwell did this overview and they did use charts.

Mr. Flood. And a pointer.

Mr. Young. And a pointer, yes, sir. When the staff came up in these very fine surroundings they found that we could not use the charts of the size we had. So rather than making them larger, we are using what we have, and that is the small charts. I hope this meets the chairman's needs and those of the rest of the committee. If it does not, we also can provide the subcommittee with the large charts, but none of us will be able to see them in this large room. So I would like to proceed and highlight from the small charts.

We appreciate this opportunity to give this overview. As I tried to explain to the Secretary this morning, this is a descriptive overview, it is neither political nor analytical. We leave the political and analytical to his appearances and those of his other associates.

[Chart 1 follows:]

HEW BUDGET IN BRIEF

[In billions]

	1973	1974	1975	1975 change over 1974
Federal funds:				
Budget authority (appropriations)	$31.6	$35.6	$35.1	$−0.5
Outlays	26.7	32.3	36.1	+3.8
Trust funds:				
Budget authority (receipts)	60.0	73.8	81.9	+8.1
Outlays	57.8	67.4	78.2	+10.8
Interfund adjustment (payments to social security trust funds)—Budget authority/outlays	−2.4	−3.0	−3.3	−.3
Total budget authority	89.2	106.4	113.7	+7.3
Total outlays	82.1	96.7	111.0	+14.3

BUDGET IN BRIEF

Mr. Young. Let me start with chart 1, the HEW budget in brief. Let me just point out several items here that may be of interest.

The HEW budget represents about 36.5 percent of the total Federal budget. In terms of "share of market" that has increased in the last few years.

Mr. Flood. What percent?

Mr. Young. 36.5 percent of the total Federal budget.

Mr. Flood. When you refer to the HEW budget are you including social security and other funds?

Mr. Young. Yes, sir. I will go through that, and the largest amount of that——

Mr. Flood. Is uncontrollable items.

Mr. Young. In terms of uncontrollables generally, this year the entire Federal budget is considered to be about 74 percent in the noncontrollable category—trust funds, veterans benefits, interest on the Federal debt, things of that nature.

UNCONTROLLABLE PROGRAMS

Mr. Flood. Let's have a listing of the uncontrollable programs. Will you tack on to the total for 1974 and 1975 budget, the budget authority, the controllable and the uncontrollable programs, then give us a detailed breakdown by each item of the amount for the uncontrollable part. There is a lot of talk about impoundment, and I see you use the term "reserve." In view of the publicity and uncertainty and not knowing what impoundment is, and when is it impounded, what can the President impound, why did he change his mind, this would help a good deal.

Mr. Young. We will be glad to do that, Mr. Chairman.

In the 1975 proposed budget only 6.1 percent of the Department of Health, Education, and Welfare's outlays are controllable.

[The information follows:]

Noncontrollable programs are those programs for which the basic authorizing legislation establishes certain conditions or requirements, which, when met, obligate the Federal Government to provide the necessary funds. The budget figures are projections of the estimated amount necessary to cover what will occur in noncontrollable programs, whereas controllable programs budget figures set limits on what will occur.

In addition to noncontrollable programs, outlays to liquidate prior obligations for all programs are noncontrollable, since there is no administrative control in the budget year to withhold the outlay of these funds when the terms of a grant or contract are met.

The following is a list of noncontrollable programs in relation to the entire Department of Health, Education, and Welfare budget.

CONTROLLABILITY OF THE HEW BUDGET

[Dollar amounts in millions]

	1974		1975	
	Budget authority	Outlays	Budget authority	Outlays
Total budget	$106, 462	$99, 774	$113, 673	$114, 321
Federal funds	(32, 639)	(32, 334)	(31, 773)	(36, 112)
Trust funds	(73, 823)	(67, 440)	(81, 900)	(78, 200)
Less Federal funds noncontrollables	19, 310	25, 227	22, 096	30, 874
Public assistance	(12, 787)	(12, 895)	(12, 968)	(12, 844)
Supplemental security income	(1, 844)	(1, 824)	(4, 373)	(4, 373)
Special benefits for disabled coal miners	(987)	(971)	(863)	(866)
Payments to social security trust funds	(3, 110)	(3, 001)	(3, 345)	(3, 345)
Interest payments and other debt service	(409)	(405)	(440)	(430)
Assistance to Cuban refugees	(129)	(128)	(60)	(72)
Other noncontrollables	(44)	(43)	(43)	(41)
Outlays from obligated balances		(5, 960)		(8, 903)
Less trust funds noncontrollables	73, 823	65, 796	81, 900	76, 432
OASDI	(58, 344)	(54, 362)	(65, 184)	(63, 000)
Medicare	(15, 477)	(11, 433)	(16, 714)	(13, 422)
Other trust funds	(2)	(1)	(2)	(1)
Total, noncontrollables	93, 133	91, 023	103, 996	107, 297
Balance, Federal fund controllables	13, 329	7, 107	9, 677	5, 238
Balance, trust fund controllables		[1] 1, 644		[1] 1, 777
Total, controllables	13, 329	8, 751	9, 677	7, 015
Percent of budget	12. 5	8. 8	8. 5	6. 1

[1] Administrative expenses of Social Security Administration.

LEGAL BASIS FOR IMPOUNDMENTS

The Director of the Office of Management and Budget, under authority delegated by the President, is required to apportion funds provided by the Congress. The apportionments are required under the Anti-Deficiency Act (31 U.S.C. 665) and generally are for the current fiscal year. Under the law, such apportionments limit the amounts which may be obligated during specific periods.

The Anti-Deficiency Act authorizes the withholding of funds from apportionment to provide for contingencies; or to effect savings made possible by or through changes in requirements, greater efficiency of operations, or other developments subsequent to the date on which the funds were made available. There are also occasions when specific provisions of law provide that the funds should be available for use over periods longer than 1 year; in such cases, they generally are not fully apportioned in the current year, and the unapportioned part is withheld, to be released later for use in the next year or years. Thus, some amounts are withheld from apportionment, either temporarily or for longer periods. In these cases, the funds not apportioned are said to be held or placed "in reserve." This practice is one of long standing and has been exercised by all recent administrations as a customary part of financial management.

On occasion, the Congress has explicitly required that an amount be placed in reserve pending an administrative determination of need; for example, the 1973 Agriculture-Environmental and Consumer Protection Appropriation Act—Public Law 92-399. Most reserves, however, are established upon the initiative of the executive branch based on an operational knowledge of the status of the specific projects or activities. For example, when the required amount of work can be accomplished at less cost than had been anticipated when the appropriation was made, a reserve assures that savings can be realized and, if appropriate, returned to the Treasury. In other cases, specific apportionments sometimes await: (1) Development by the affected agencies of approved plans and specifications; (2) completion of studies for the effective use of the funds, including necessary coordination with the other Federal and non-Federal parties that might be involved; (3) establishment of a necessary organization and designation of accountable officers to manage the programs; or (4) the arrival of certain contingencies under which the funds must by statute be made available; for example, certain direct Federal credit aids when private sector loans are not available.

From time to time, additional reserves are established for such reasons as the necessity to conform to the requirements of other laws. An example is the executive's responsibility to stay within the statutory limitation on the outstanding public debt.

Mr. YOUNG. Let me mention a couple other highlights on chart No. 1, which tie to the remarks you just made.

The 1973 column here throughout these charts is the 1973 congressional appropriation. The 1974 numbers are the 1974 appropriations minus the 5-percent compromise. Let me explain what those two columns mean——

Mr. FLOOD. What 5-percent compromise?

Mr. YOUNG. As you recall, late last fall it was agreed between the House and the Senate that the administration could withhold up to 5 percent of any activity, program, or project of what the two Houses agreed to. The total could not exceed $400 million. There is a detailed table in the report of the conference for each one of those items showing what the 5 percent is.

Mr. FLOOD. What do you mean by report of the conference?

Mr. YOUNG. This is report No. 93-682, 93d Congress, first session. The detailed tables start on page 8 and go through page 20. They show the effect on each program and each activity of the agreed to $400 million reduction.

Let me say relative to these remarks, and also in explaining what the 1973 and 1974 columns mean, that there are no impounded funds in the 1973 and 1974 columns. There are no proposed rescissions as was the case last year.

RESCISSION

Mr. FLOOD. What is a rescission?

Mr. YOUNG. In 1973 there was a proposal by the administration for the Congress to amend the sum that the Congress had already appropriated and the President had signed into law. This is how I define rescissions, and it is not quite the technical definition but I think it is clear what the intent is.

As I recall none of those rescissions were approved by the Congress. What I am saying is that this year the figures are easier to understand. If I may say so, they are cleaner figures because you don't have the problem of trying to explain impoundment, nor do you have the problem of trying to explain rescissions which makes the numbers very difficult to understand.

Also I would like to make one last remark on the still great growth of Government that has occurred in the last 10 years. On the bottom of the chart, the total outlays proposed for 1975 are $111 billion. Interestingly enough, $111 billion was the total Federal budget in outlay terms in 1963, 12 years ago. That is all I have on the first chart, Mr. Chairman, unless the chairman or staff have questions.

[Chart 2 follows:]

HEW BUDGET BY OPERATING AGENCY

[Budget authority in millions]

	1973	1974	1975	1975 change over 1974
Health agencies	$5,355	$5,303	$4,756	−$547
Education division	6,362	8,991	6,153	−2,838
Social Rehabilitation Service	15,211	14,150	14,205	+55
Social Security Administration[1]	61,638	77,155	87,548	+10,393
(Outlays)	(58,759)	(70,628)	(83,847)	(+13,219)
Special institutions	86	86	118	+32
Office of Human Development	672	685	724	+39
Other departmental activities	102	113	196	+83
Adjustment for miscellaneous receipts	−29	−33	−35	−2
Total, HEW	89,397	106,450	113,666	+7,216
(Outlays)	(82,040)	(96,768)	(110,959)	(+14,191)

[1] Net of interfund adjustments

HEALTH AGENCIES

Mr. YOUNG. I only have a couple highlights on chart 2 because we are going to move right on into the detail.

You will note at the top the "Health agencies." You note in the extreme right hand column there is a proposed reduction of $547 million. We are going to go into this in some detail, but let me point out now that the majority of that proposed reduction is made up of health construction items. In there is a reduction in Hill-Burton of $197 million, and a proposed reduction of $114 million——

Mr. FLOOD. What is Hill-Burton?

Mr. YOUNG. Hill-Burton is the construction program that provides local and State agencies or nonprofit schools or organizations with Federal funds primarily for hospitals, health centers.

Mr. FLOOD. Bricks and mortar?

Mr. YOUNG. Yes, sir, construction.

Mr. FLOOD. Or renovation.

Mr. YOUNG. Yes. At the present time most of the Hill-Burton funds, some 90 percent of it, is actually being spent for renovation rather than new self-standing facilities.

Mr. FLOOD. Renovations and modernizations?

Mr. YOUNG. Yes, sir.

There is also in that minus $547 million, a proposed reduction of $114 million in health teaching facilities. There also is in that number a proposed reduction of $198 million in health manpower. This is all I would like to say about these at this time because we will want to say quite a lot more in detail about them later on.

Mr. FLOOD. We will want to know a lot more about it later on too.

Mr. YOUNG. You certainly will and that will go on through most of the spring, sir.

Mr. FLOOD. Something like Tennyson's Brook.

Mr. YOUNG. It will bubble a lot.

EDUCATION

The other item that I would like to point out, which is difficult to understand in the numbers, is the Education Division. If you will look in the 1974 column, it is proposed that appropriations be authorized for almost $9 billion. As you look at your 1975 column you find a request for only about $6 billion in budget authority. The reason that the 1974 column is as large as it is is the proposal to advance fund, primarily title I of the education legislation, which will come before the Congress later on this year.

I just wanted to point out at this time to clarify those very large numbers which then drop down again in 1975.

Mr. FLOOD. Your timing is good because it comes up tomorrow I think.

Mr. YOUNG. In the House, my understanding is that the legislation is in reasonably good shape.

Mr. FLOOD. You get many opinions about that.

Mr. YOUNG. That is what I was told.

Mr. FLOOD. The last I understood it was a can of worms.

Mr. YOUNG. I would have no comment on that.

OTHER DEPARTMENTAL ACTIVITIES

The last number I want to talk to on chart 2, which I will not come back to unless there are questions, is the item called other departmental activities. It shows a proposed increase of $83 million in 1975. Most of that increase is made up of the following items: $33 million for the proposed phase down of the Office of Economic Opportunity during 1975.

OEO

Mr. FLOOD. OEO?

Mr. YOUNG. That is correct.

Mr. FLOOD. What do you mean by phase out? Are you wiping it out altogether?

Mr. YOUNG. The administration's proposal is to bring to an end by the end of 1975 the Office of Economic Opportunity.

Mr. FLOOD. By the end of 1975?

Mr. YOUNG. Yes.

Mr. FLOOD. Not only the fragmented parts that go to Labor and HEW as of now, but you are going to put the curtain down on the whole act. Is that it?

Mr. YOUNG. That is the administration's proposal, sir, although the Legal Services sanction and the community economic development program will be transferred to the Legal Services Corporation and the Department of Commerce, respectively.

Mr. FLOOD. Of course, you are presenting the administration's proposal. You are aware there is strong opposition in the House to that being done in toto, but that is another subject.

Mr. YOUNG. Yes, sir. It is my understanding that legislation hasn't been sent up on the Hill yet.

Mr. FLOOD. That is right.

ALLIED SERVICES LEGISLATION

Mr. YOUNG. Also there is proposed legislation for reintroduction of what the administration calls allied services. This would be to the tune of $20 million in 1975. These funds would go to State and local governments to try to improve their delivery of human service programs.

PAYMENTS TO GENERAL SERVICES ADMINISTRATION

The last major item comprising the $83 million is $16 million that HEW would pay to GSA for the use of office space.

Mr. FLOOD. What is GSA?

Mr. YOUNG. General Services Administration.

Mr. FLOOD. What is their job?

Mr. YOUNG. General Services Administration is generally considered to be the executive branch's housekeeper. Property purchases, property management, communications management, motor pool management.

Mr. FLOOD. They are the landlord for Government buildings and sell surplus property and things like that?

Mr. YOUNG. Correct.

Last year the Congress passed legislation which requires that each agency pay into a revolving fund money for the space they use. The funds are to be used to construct new Federal buildings, a revolving fund type arrangement. That is under Public Law 92-313; better known as SLUC, standard level user charge.

Unless there are questions I will leave chart 2.

[Chart 3 follows:]

HEALTH PROGRAMS

[Dollars in millions]

	1973	1974	1975	1975 change over 1974
Food, drug and product safety	$149	$165	$200	+$35
Health services	1,082	1,176	1,177	+1
Preventive health services	160	136	138	+2
Biomedical research	1,758	1,781	1,835	+54
Alcoholism, drug abuse and mental health	881	833	735	−98
Health resources	1,249	1,137	574	−563
Assistant Secretary for Health	76	74	97	+23
(PSRO's)	(5)	(34)	(58)	(+24)
Subtotal, health agencies	5,355	5,303	4,756	−547
Outlays	(4,341)	(5,720)	(5,592)	(+322)
Medicare and medicaid benefits	(14,079)	(18,007)	(20,699)	(+2,692)
Total, health outlays	(18,420)	(23,277)	(26,291)	(+3,014)

HEALTH PROGRAMS

Mr. YOUNG. I am on chart 3, health programs. I have two or three highlights here before we move into further detail in the health area.

Let me point out that the food, drug, and product safety request for appropriations does not come before this committee but goes before the Agriculture-Environmental and Consumer Affairs Subcommittee.

Mr. FLOOD. You mean the Food and Drug Administration is no longer under the jurisdiction of HEW?

Mr. YOUNG. It is under the jurisdiction of HEW, but it is not under the jurisdiction of this particular subcommittee in terms of appropriations.

Let me briefly tell you where the $35 million is.

Again $17 million of the $35 million is for the GSA rental, $6 million is for pay costs, and $12 million is for increases in program costs. That is all we will be saying about food, drug, and product safety unless there are questions.

HEALTH RESOURCES

Let me now move to health resources. Here you find a proposed reduction of $563 million, which is that portion of the $547 million net reduction for the health agencies. This is a proposed reduction in health facilities and in health manpower. We are going to take this up in some detail in a subsequent chart

MEDICAID AND MEDICARE BUDGET

I would call your attention to another interesting set of numbers, at least to me, being used in the program, medicaid and medicare benefits. It is interesting to note the growth there from $14 billion to $20 billion in 1975.

Mr. FLOOD. $14 billion when, what year?

Mr. YOUNG. It goes from $14 billion in 1973——

Mr. FLOOD. What was it in 1974?

Mr. Young. $18 billion.

Mr. Flood. What is it now?

Mr. Young. $20,699 million in 1975, medicare and medicaid benefits.

Mr. Flood. It has gone up $2,692 million since 1974?

Mr. Young. Yes.

Mr. Flood. Medicare and medicaid?

Mr. Young. Yes. We are going to talk about those in some detail.

Mr. Flood. You had better.

Mr. Young. Federal health outlays now constitute approximately 25 percent of the total national expenditures for health care compared to 9 percent in 1965 prior to the enactment of medicare and medicaid.

[Chart 4 follows:]

HEALTH SERVICES ADMINISTRATION

[Budget authority in millions]

	1973	1974	1975	1975 change over 1974
Comprehensive health services	$299	$295	$290	−$5
Health maintenance organizations		65	60	−5
Maternal and child health	267	266	266	
Family planning	131	101	101	
Migrant health	24	24	24	
Indian health	220	250	281	+31
National Health Service Corps	8	10	9	−1
PHS hospitals	96	105	109	+4
Program administration and other	37	60	37	−23
Total, Health Services Administration	1,082	1,176	1,177	+1

COMPREHENSIVE HEALTH SERVICES

Mr. Young. Turning to chart 4 where we are now going into greater detail in the health services area, the first item is comprehensive health services. Of this $90 million goes to health grants, what they call comprehensive health grants to State governments. That $90 million has stayed at about that level over the past few years. The remainder of the——

Mr. Flood. When you say $90 million on comprehensive health services goes from the Federal Government to the States, do you mean that the Federal Government makes the allocation to the respective States?

Mr. Young. Yes, sir.

Mr. Flood. And then the allocation by the States within the jurisdiction of the State is made by the respective responsible State agency?

Mr. Young. Yes, sir. $200 million of this goes for community health centers.

This $290 million serves about 1,200,000 people with various services. With these funds that are proposed here there should be about a 10 percent increase in the number of people served in 1975. That is an increase of about 120,000.

Some may wonder why you would decrease this program by a small $5 million. This is based upon what we estimate as increased payment from third parties.

Mr. Flood. You are speaking of health maintenance organizations?

Mr. Young. No, I am not, sir. I will be in a minute.

Mr. FLOOD. All right.

Mr. YOUNG. All I am saying is that we anticipate about $5 million worth of additional receipts, so this is not a program reduction we are proposing in the minus 5 million in the 1975 budget.

HEALTH MAINTENANCE ORGANIZATION

Now I will be talking about health maintenance organizations.

Mr. FLOOD. Health Maintenance Organizations more commonly known as HMO's.

Mr. YOUNG. Yes, sir.

This is new legislation.

Mr. FLOOD. What date?

Mr. YOUNG. It was December 29, 1973.

These funds in both 1974 and 1975 are made up of two types. Again we have a revolving fund here, and in 1974 that is $35 million, and it is only $15 million in 1975. The reason that it is larger in 1974 than 1975 is because it is a revolving fund and you need more initial financing than you do in the second year. It is not a program reduction.

Also there are grants and contracts and program support proposed here, and in fiscal year 1974 this accounts for $30 million. Therefore the revolving fund of $35 million plus the grants and contracts of $30 million make up the $65 million.

Has that supplemental been approved?

Mr. MILLER. It was just marked up by this committee.

Mr. YOUNG. In 1975 the $60 million is made up of $15 million in revolving funds and $45 million in grants and contracts and program support. In other words, the grants and contracts increased by $15 million over 1974.

MATERNAL AND CHILD HEALTH

I would like to point out, Mr. Chairman and members of the committee, that on maternal and child health in 1975 the project authority is being folded into the formula grants. This is in accordance with section 502 of the Social Security Act. So if you are looking for your project grant authority in 1975, you will find that it doesn't exist, it has been folded into the formula grants.

Mr. FLOOD. Who gives birth to the formula?

Mr. MILLER. It is in the law.

FAMILY PLANNING

Mr. YOUNG. I would like to talk briefly about the family planning which stays level. If you look just at this part of the HEW budget it understates markedly the total amount of funds that will be going into family planning. We have prepared a special chart that I found very useful which pulls all of the family planning funds together. When you do this you find that there will be a total increase from $205 million in 1974 to $222 million in 1975. We would like to provide that table for the record and for the use of the committee. I found it quite useful.

[The table follows:]

DHEW FUNDING FOR FAMILY PLANNING SERVICES

[Dollars in millions]

	Funds provided			People served		
	1973	1974	1975	1973	1974	1975
Title X, PHS Act	$124.9	$94.5	$94.5	1.6	[1] 1.6	1.6
Maternal and Child Health Services	35.2	35.2	35.2	1.3	1.3	1.3
Medicaid	22.4	30.6	36.0	.6	.7	.8
AFDC Social Services	28.5	43.3	55.9	[2] (1.5)	[2] (2.5)	[2] (3.3)
Indian Health Services	1.0	1.2	1.2	.2	.3	.3
Total	212.0	204.8	222.8	3.7	3.9	4.0

[1] Excludes persons to be served by $30,400,000 in 1973 funds released for use in 1974 on a 1-time basis.

[2] Many recipients of social services receive family planning services under medicaid. Social services generally covers counseling and referral.

Mr. YOUNG. These funds in the aggregate will provide services for about 4 million individuals whereas the private sector will provide about another million. So you have about a total of 5 million people for whom these types of services can be provided.

INDIAN HEALTH

Indian health is not heard by this committee. There is a marked increase proposed by the administration in this area, and it is made up of about $23 million in mandatory costs that are increasing. Also a marked increase in the facilities for the Indian Health Service. Also additional funds for mandatory and contract services. I will not go into the details of that unless somebody is interested.

Mr. FLOOD. Going back to family planning, out of an abundance of caution will you show on the record when you are talking about family planning you are in no way engaging in the highly controversial subject of the abortion problem?

Mr. YOUNG. That is a very good point, Mr. Chairman. It had not crossed my mind. That shows you how little I know about some of these things.

Mr. FLOOD. You have a lot of company so don't worry about that.

PUBLIC HEALTH SERVICE HOSPITALS

Mr. YOUNG. I would like to mention briefly the Public Health Services hospitals. It is my understanding there has been some controversy about this.

Mr. FLOOD. That is an understatement, yes.

Mr. YOUNG. The Congress did pass legislation mandating these hospitals be kept open and that the services be equivalent to what they were in January of 1973. The administration intended to do just that. There are only about 42 vacancies, and the professional staff ratio is increasing. It was about 1.82, it is now 1.97. In other words, we are meeting the commitment by increasing the number of professional and supporting people serving the beneficiaries of these services.

Mr. Flood. How about your paramedics?

Mr. Young. I can't answer that.

Mr. Flood. You are going up on the pro's. Do you have any figures on paramedics?

Mr. Miller. The ratios we gave include total staff.

Mr. Young. I am talking total staff ratio.

Mr. Flood. That thing is being split more and more every year. These paramedics say it makes quite a difference instead of being bracketed in the pro's. I think they have some merit to that.

NATIONAL HEALTH SERVICE CORPS

Mr. Young. Let me touch on one last item here, the National Health Service Corps. It looks like there is a slight reduction in that, but that $1 million proposed reduction is nothing more than a nonrecurring cost. The proposal for 1975 would provide 146 new Corps positions in the National Health Service Corps.

There are about 125 counties that do not have doctors. Forty-seven of these will have doctors by the end of 1975.

I would also like to point out that not all counties without a doctor necessarily receive poor medical attention. A case in point is the county of Stafford which is just to the south of us in Virginia, which is surrounded by very good medical facilities. It does not have a doctor and yet the medical attention it gets, I understand, is quite good.

Mr. Flood. If they have the gasoline I guess.

Mr. Young. I understand the situation in that part of the State hasn't been all that bad, sir.

[Chart 5 follows:]

NATIONAL INSTITUTES OF HEALTH

[Budget authority in millions]

	1973	1974	1975	1975 change over 1974
National Cancer Institute	$486	$527	$600	+$73
National Heart and Lung Institute	289	287	309	+22
Other research institutes	833	793	794	+1
Research resources	101	127	83	−44
National Library of Medicine	28	26	28	+2
Other activities	21	21	21	
Total, NIH	1,758	1,781	1,835	+54

NATIONAL INSTITUTES OF HEALTH

Mr. Young. I now move to chart 5, National Institutes of Health.

Mr. Flood. We also use the term NIH for the National Institutes of Health.

Mr. Young. Yes, sir. In the National Cancer Institute you see a proposed expansion of $73 million. This is spread across all areas of cancer research and work.

National Heart and Lung Institute. You see a proposed increase of $22 million. This covers all areas of research in the National Heart and Lung Institute, plus funds for six national research and development centers whose objective is to translate the results of research into clinical practice.

You will note a signficant proposed decrease in the line "research resources."

Mr. Flood. What about other research institutes?

Mr. Young. Other research institutes stay about level.

Mr. Flood. How much?

Mr. Young. At $794 million.

Mr. Flood. That is an increase in 1975 over 1974 of $1 million. Right?

Mr. Young. That is correct.

Mr. Flood. The National Cancer Institute in 1975 goes up $73 million over 1974.

Mr. Young. Yes, sir.

Mr. Flood. The National Heart and Lung Institute goes up $22 million.

Mr. Young. That is correct.

Mr. Flood. Over 1973.

Mr. Young. Over 1974.

Mr. Flood. All of the other research institutes, of the National Institutes of Health, go up $1 million. All of them put together.

Mr. Young. That is correct.

Mr. Flood. Will you put all of the others in the record?

Mr. Young. Yes, sir. The total list.

[The information follows:]

OTHER RESEARCH INSTITUTES

Agency/appropriation	1974 comparable	1975 estimate	Increase of 1975 over 1974
National institute of Dental Research	43,955,000	43,959,000	+4,000
National Institute of Arthritis, Metabolism, and Digestive Diseases	153,136,000	152,961,000	−175,000
National Institute of Neurological Diseases and Stroke	119,993,000	119,958,000	−35,000
National Institute of Allergy and Infectious Diseases	110,461,000	110,404,000	−57,000
National Institute of General Medical Sciences	166,805,000	168,329,000	+1,524,000
National Institute of Child Health and Human Development	124,950,000	124,897,000	−53,000
National Eye Institute	39,998,000	39,947,000	−51,000
National Institute of Environmental Health Sciences	28,338,000	28,684,000	+346,000
John E. Fogarty International Center	4,762,000	4,784,000	+22,000
Total	792,398,000	793,923,000	+1,525,000

RESEARCH RESOURCES

Mr. Young. "Research resources." Here you see a proposed reduction of $44 million. This proposal is based on the proposition that there is now adequate general research capacity. Many of these funds in the past few years have gone to build that research capacity. It is now contended this capacity is generally in place.

You will note though that we do propose $83 million for health resources in 1975. This is to continue support for specialized research facilities such as primate centers.

POSTDOCTORAL RESEARCH TRAINING PROGRAM

I think there is one other point on this chart. If you will look under the 1975 column at the bottom where it says total, NIH, and you look at the 1975 column, it says $1,835,000,000. In this sum is $56 million for the postdoctoral research training program. This was a new program started in 1974 with a budget authority of approximately $29 million to support 2,060 individuals in postdoctoral training. In 1975 it is proposed that this go to $55 million to support 3,700 individuals in postdoctoral research training.

If there are no questions I will go to chart 6.

[Chart 6 follows:]

ALCOHOLISM, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

[Budget authority in millions of dollars]

	1973	1974	1975	1975 change over 1974
General mental health:				
Research and training	$200	$190	$150	−$40
Community mental health	205	189	199	+10
Drug abuse:				
Research and training	48	52	44	−8
Community programs	167	176	157	−19
Alcoholism:				
Research and training	20	15	12	−3
Community programs	140	113	78	−35
St. Elizabeths Hospital	36	40	42	+2
Administration and information	64	58	53	−5
Total	881	833	735	−98

ALCOHOLISM, DRUG ABUSE AND MENTAL HEALTH

Mr. Young. Alcoholism, Drug Abuse, and Mental Health Administration.

"General mental health, research and training." Here you will note a proposal for a reduction of $40 million; $35 million of this reduction is to phase out training grants and fellowships. This is in keeping with the administration's general approach of phasing down specialized training over a long-term period and focusing on short-term training. We are going to talk a little more about that when we get to the educational grants and so on.

Also if you look under "Drug abuse, research, and training," you will find there is a proposed reduction of $8 million in 1975. This is also related to a phaseout of long-term categorical training.

COMMUNITY DRUG ABUSE PROGRAMS

There certainly can be a question in the drug abuse area particularly when you come to community programs and the recommendation to reduce this by $19 million. Let me point out that even with the proposed reduction of $19 million——

Mr. Flood. That is community drug abuse programs?

Mr. Young. Community programs under drug abuse.

Mr. Flood. Cutting them down $19 million?

Mr. Young. Yes, proposed.

Mr. FLOOD. Are you going to train addicts or what?

Mr. YOUNG. The proposal is based on these propositions: That we should maintain the 95,000 present treatment capacity. That is the capacity we have now and on an annual basis that can service about 161,000 people. So you maintain the present capacity, but the reduction is based upon the proposition that the Federal Government shift over more to prevention and leaving more of the treatment to the States. Those are the propositions on which these numbers are proposed.

COMMUNITY ALCOHOLISM PROGRAMS

We also have a similar situation with alcoholism particularly when it comes to community programs. Here the budget proposes in 1975 a reduction of $35 million leaving a proposal for $78 million. The reduction of $35 million is in project grants, of which 50 demonstration or project grants will be completed this year. So, even though the administration proposes a reduction of $35 million, there are $20 million in the $78 million that are proposed for new projects. Many projects have been completed.

Mr. FLOOD. How do you complete a project?

Mr. YOUNG. These are demonstration projects. They have a beginning and an end. Some of them, I understand, have been successful and it is my understanding that some have not been so successful.

Mr. FLOOD. Many of those projects were born at a time when it was decided alcoholism was now to be treated as a disease, contrary to the way it was before. Now that you have declared it a disease it seems strange you would start cutting back on the community program. I thought your business was that you are against disease.

Mr. YOUNG. I fully agree with your interpretation that alcoholism is now considered a disease, but 50 of these projects have been completed in 1974 alone, as I say, some successful, some not so successful, and within the $78 million proposed there is $20 million for additional new projects, new techniques, new approaches.

SUMMARY OF ALL HEW ALCOHOLISM AND DRUG ABUSE PROGRAMS

I also find that this table, No. 6, has been most confusing to me and to others, and therefore to assist the committee I have had a table prepared which shows all of the programs of HEW that deal with alcoholism and drug abuse, and this shows a quite different picture because it shows for instance in the vocational rehabilitation area a considerable amount of funds are going to this area. I would like to insert with your permission, Mr. Chairman, these two tables in the record at this point.

[The information follows:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE—DRUG ABUSE PROGRAMS

[Dollar amounts in millions]

Drug abuse	1969		1970		1971		1972		1973		1974		1975	
	Budget authority	Outlays	Budget authority	Outlays	Budget authority	Outlays	Budget authority	Outlays	Budget authority	Outlays	Budget authority	Outlays	Budget authority	Outlay
Alcohol, Drug Abuse and Mental Health Administration:														
Research	10.0	10.0	11.7	12	14.1	15	26.9	28.0	28.6	22.0	37.0	32.0	34.0	29.0
Training	.3	.2	1.5	1	20.0	1	9.7	7.0	12.5	7.0	15.1	12.0	10.0	11.0
Community programs:														
Project grants	10.2	5.0	7.4	3	27.8	12	69.0	30.0	152.3	75.0	160.8	115.0	122.0	133.0
Formula grants									15.0	5.0	15.0	9.0	35.0	15.0
Subtotal, ADAMHA	20.5	15.2	20.6	16	43.9	28	105.6	65.0	208.4	109.0	227.9	168.0	201.0	188.0
Social and Rehabilitation Service:														
Social Services	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	58.2	58.0	64.0	64.0	73.6	73.0
Vocational Rehabilitation	(1)	(1)	(1)	(1)	2.2	2	5.9	6.0	6.9	7.0	7.5	7.0	8.5	9.0
Subtotal, SRS	(1)	(1)	(1)	(1)	2.2	2	5.9	6.0	65.1	65.0	71.5	71.0	82.1	82.0
Office of Education:														
Drug Abuse Education					6.0	4	12.4	7.0	12.4	8.0	5.7	10.0	0	5.6
Elementary and Secondary Education							1.3	1.3	1.3	1.3	1.3	1.3	0	0
Subtotal, OE					6.0	4	12.7	8.3	13.7	9.3	7.0	11.3	0	5.6
Total, drug abuse—DHEW	20.5	15.2	20.6	16	52.1	34	125.2	79.3	287.3	183.3	306.4	250.3	283.1	275.6

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[1] Dollars not identifiable.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE—ALCOHOLISM PROGRAMS

[In millions of dollars]

Alcoholism	1969		1970		1971		1972		1973		1974		1975	
	Budget authority	Outlays	Budget authority	Outlays	Budget authority	Outlays	Budget authority	Outlays	Budget authority	Outlays	Budget authority	Outlays	Budget authority	Outlays
Alcohol, Drug Abuse and Mental Health Administration:														
Research	5.7	6	5.3	6	6.1	7	7.9	9	11.6	6	8.5	8	10.4	11
Training	.7	1	1.2	2	1.3	2	4.9	5	8.9	3	6.8	5	1.9	7
Community programs:														
Project grants					8.1	3	39.3	12	80.0	23	67.0	32	32.0	61
Formula grants							30.0	6	60.0	19	45.6	29	45.6	55
Subtotal, ADAMHA	6.4	7	6.5	8	15.5	12	82.1	32	160.5	51	127.9	74	89.9	134
Social and Rehabilitation Service:														
Social services, CSA	(1)								34.8	34	38.3	38	44.1	44
Vocational rehabilitation	(1)		[1] 19.6	19	[1] 26.2	26	[1] 26.1	26	28.5	29	31.3	30	34.2	35
Total, alcoholism, DHEW	6.4	7	26.1	27	41.7	33	108.2	58	223.8	114	197.5	142	168.2	213

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[1] Dollars not identifiable.

Mr. YOUNG. I would like to call attention first to the drug-abuse table and the total in the right-hand corner at the bottom of that table, which shows the budget authority in 1974 for all the HEW drug-abuse programs at $306.4 million with outlays estimated at $250.3 million.

Also I would call attention to the 1975 proposed column where the budget authority is $283.1 million and the outlays go to $270.6 million. Somebody made a correction. I guess it is $275.6 million estimated outlays in 1975.

Mr. FLOOD. So despite the fact that you had a bigger appropriation in 1974 your expenditures proposed for 1975 will be above those in 1974?

Mr. YOUNG. That is the point, Mr. Chairman.

I would like to now turn to the alcoholism chart and call attention again to the lower right-hand corner where for fiscal year 1974 it is estimated that budget authority for the alcoholism program will be $197.5 million with estimated outlays of $142 million as contrasted with the proposal in fiscal year 1975 of $168.2 million in budget authority and outlays of $213 million. So you see the same contrasting increase in outlays.

Mr. FLOOD. While in 1974 you had $197.5 million, your outlay was $122 million?

Mr. Young. Correct.

Mr. FLOOD. However, in 1975 you are asking for only $168.2 million. Nevertheless you proposed to spend $213 million.

Mr. YOUNG. That is correct.

[Chart 7 follows:]

HEALTH RESOURCES ADMINISTRATION

[Budget authority in millions]

	1973	1974	1975	1975 change over 1974
Health resources planning			$75	+$75
Comprehensive health planning	$38	$42		—42
Regional medical programs	144	75		—75
Research and evaluation	64	78	68	—9
Health manpower:				
Institutional assistance	265	267	159	—108
Student assistance	132	134	90	—44
Special projects	196	166	120	—46
Subtotal	593	567	369	—198
Construction:				
Medical facilities	214	197		—197
Teaching facilities	120	114		—114
Interest subsidies	2	2	2	
Subtotal	336	313	2	—311
National health statistics	20	21	24	+3
Administration and other	55	42	35	—7
Total	1, 249	1, 127	574	—563

HEALTH RESOURCES

Mr. YOUNG. I would like to move to chart 7. This is by far the most significant table of the series of tables which we bring before you.

Here we now begin to pick up in detail the proposed reductions that I called the committee's attention to earlier in my presentation. Let us start with "Health resources planning."

Mr. FLOOD. Before you go any further I just saw this a moment ago, but take a look at this right-hand column. Everything you are going to talk about now is minus, the whole page.

Mr. YOUNG. That is true with one exception, the 1975 proposed legislation at the top and a small plus-3 down in "National health statistics." Your interpretation of the table is correct.

The administration is proposing legislation which is not yet on the Hill in the health resources planning area with an estimate of budget authority of $75 million in 1975. The proposal here is to fold in the various approaches to health planning that have gone on in the past, that is comprehensive health planning, regional medical programs which are not only planning but the delivery of services. Also there is a small amount of money in Hill-Burton that goes for planning.

COMPREHENSIVE HEALTH INSURANCE PROGRAM

It is proposed that these be combined and that this be the beginning of the phase in toward comprehensive health insurance program.

Mr. FLOOD. Comprehensive health insurance program?

Mr. YOUNG. Yes; better known as CHIP.

Mr. FLOOD. Do you need a law for that?

Mr. YOUNG. Yes, sir.

Mr. FLOOD. What day or year are you going to get it?

Mr. YOUNG. I would not like to guess at that, but we anticipate coming before this committee next year to begin the program so that it will be fully operational in 1977.

Mr. FLOOD. While you are waiting you are going to do all of these things hoping against hope?

Mr. YOUNG. It is proposed these things be done. That is to take the specialized approaches to health planning and pull them together involving all of those interested in both the supply and demand side of health planning at the State and sub-State level.

Mr. FLOOD. Realizing in other certain circumstances you may propose but Congress may dispose?

REGIONAL MEDICAL PROGRAMS

Mr. YOUNG. Yes, sir, fully understood, sir.

But also in terms of the regional medical programs which are of great interest to this committee and many other Members of Congress, many of the previous projects that were handled under the regional medical programs are now being handled by such groups as National Cancer Institute, National Heart and Lung Institute, and also medicare in the case of kidney disease.

Also, as the chairman and members of the committee know, we are considering that certain of the funds available in 1973 and 1974 for regional medical programs be perhaps used for other things such as hospitals in the inner cities.

We have discussed health resources planning and the administration's proposed legislation which is not yet on the Hill and its proposal to fold in these various other types of planning.

Mr. **Flood.** When are they going to send it up do you know?

Mr. **Forbush.** It should be very soon. They were working on the final specifications of it last week. I know the Rogers committee will be holding hearings shortly.

Mr. **Young.** Does the House have legislation somewhat comparable to this in the Rogers committee?

Mr. **Forbush.** That is right.

Mr. **Young.** I would like to point out in the regional medical program there is $164 million available for obligation from a combination of 1973 and 1974 funds. The Secretary has written to both committees suggesting reprogramming of that. I think we already have your answer on that. So in that case those funds would be available for regional medical programs, and it is my understanding that the 1973 funds are available for obligation through February of 1973.

Mr. **Flood.** Regional medical programs?

Mr. **Young.** Yes.

Mr. **Flood.** Did you ever hear of sacred cows?

Mr. **Young.** Yes, sir.

HEALTH MANPOWER

I would like to now move on to health manpower, and you will note there that there are proposed decreases in institutional assistance to medical and professional and related schools, some reduction in student assistance and a reduction in special projects. In the health manpower area the administration also proposes to submit new legislation which would maintain the current capacity in medical and related schools that has been built up over the past few years in terms of capitation and related types of grants.

Then also to provide additional student assistance to those people who would like to be doctors——

Mr. **Flood.** Are you including nurses in that?

Mr. **Young.** Yes, sir.

PHASEDOWN OF CAPITATION GRANTS

But the administration proposes, as the numbers indicate, a phasedown over some undetermined future time of the capitation grants, on the proposition that the capacity is now in place, and that by 1985 there would be, with the present capacity, about a 50-percent increase in the number of medical doctors, 40-percent increase in the number of dentists, and 80 percent in the number of nurses.

There can be great arguments over whether this supply will meet the needs. It has been argued both ways, both academically, politically and otherwise. You will have to ask my other associates when they appear before you to explain those numbers. I am not qualified to do that.

The thrust of the administration's proposed legislation in the health manpower area would try to correct some of the problems that have not been corrected by the present legislation, that is to try to get a better focus on primary care and on some of the specializations where there are still shortages and great needs. Also to try to solve the problem of geographic maldistribution. These are some of the thrusts that the new legislation would propose.

MEDICAL FACILITIES AND TEACHING FACILITIES CONSTRUCTION

I would now like to talk briefly about construction. We have primarily two types of construction which I spoke of earlier, that is, construction for medical facilities, better known as the Hill-Burton program and for teaching facilities. As you will note it is proposed that both of these programs be zeroed out in 1975.

Let me speak briefly of the Hill-Burton program, the medical facilities program. The administration's contention is that there is generally no shortage of these types of facilities, and that the Federal Government and third party payments now provide significantly larger funds than the Hill-Burton program did.

It is estimated that the Federal Government through allowing depreciation on health facilities will provide about $790 million for health medical facilities this year, and in the private sector approximately $1 billion.

Mr. FLOOD. You are not suggesting there is not a great need for modernization of many existing facilities?

Mr. YOUNG. No, I am not, sir. I could not contend that.

But I also would like to point out that there are $385 million worth of funds that can be obligated for modernization and for medical facilities from the 1973 to 1974 moneys, and those funds to the tune of $385 million will be obligated in keeping with this administration's commitment not to impound these funds, sir.

I would also like to point out in terms of the teaching facilities, these being the funds that have gone to increase the capacity of medical, dental, and nursing, approximately $340 million worth of funds are available here for 1973 and 1974, and these funds will be obligated for these purposes.

Mr. FLOOD. The funds were impounded?

Mr. YOUNG. The 1973 funds were impounded at one time.

Mr. FLOOD. Now we have the assurance they won't be impounded again?

Mr. YOUNG. Yes, sir.

Mr. FLOOD. We hope.

Mr. YOUNG. The word of the Secretary, the Under Secretary, Mr. Laird, and all other officials connected with these propositions, sir. Should there be a breach of faith, I would not want to be sitting here.

Mr. FLOOD. You have heard the expression "I have spoken"?

Mr. YOUNG. All I can do is say what I have said, sir. I assume there will be no gamesmanship here, because I would not otherwise sit here and tell you this.

Mr. FLOOD. I am sure of that.

Mr. YOUNG. That is about what I have to say on Health Resources Administration chart 7.

[Chart 8 follows:]

EDUCATION DIVISION

[Budget authority in millions]

	1973	1974	1975	1975 change over 1974
Education grants consolidation proposed legislation		$2,852	$2,875	+$23
Categorical programs consolidated	$2,912	2,673		−2,673
Impacted area aid	661	593	340	−253
Emergency school aid	247	234	75	−159
Other elementary and secondary education	425	391	316	−75
Higher education	1,737	1,957	2,229	+272
Library resources	115	73	40	−33
National institute of education	143	101	130	+30
Postsecondary innovation	10	10	15	+5
Administration and other	112	107	133	+26
Total	6,362	8,991	6,153	−2,838
Total without advance funding supplemental	6,362	6,139	6,153	+14

EDUCATION PROGRAMS

Mr. Young. We are now on chart 8 moving into the education area. As the chairman and the members of the committee know, there is legislation before the Congress to consolidate elementary and secondary categorical grants.

In addition, the administration proposes to submit legislation for the consolidation of vocational education and adult education.

Also, the administration proposes to submit a supplemental to the tune of $2.852 billion for the advanced funding of the consolidated Elementary and Secondary Education Act. That explains the aberration in the funding that you originally saw in my earlier charts.

These proposals are made for three reasons: to allow better planning and budgeting on the part of State and local education agencies, increase their flexibility in the use of the funds, and to simplify administration.

IMPACTED AREA AID

I now go to impacted area aid which has been a favorite topic for some time in town. Here we propose for the B students a reduction of $253 million; for the A students, there would be an increase of $12 million.

Also in speaking of the B students, there would be $40 million available for any local educational group that lost more than 5 percent of their school budget in any given year.

Mr. Flood. Have you left impacted aid?

Mr. Young. I was just explaining for B students, those such as Fairfax County and Montgomery County and so forth, there is $40 million in this budget to help those school boards where not getting impacted aid for B students would cause a reduction in their budget for 5 percent or more.

Mr. Flood. You have been around town a long time. Do you know offhand how many Members of the House there are?

Mr. Miller. 435.

Mr. Flood. Four hundred and thirty-five. You know of course that 385 Members receive impacted aid. So you propose to come up here and eliminate impacted aid. Are you going to have a miracle?

Mr. Young. I think, as I recall the equity of this—by the way this helps me because I pay less taxes as a result of getting this at least when my children were going to school. I must admit personally and officially with the kind of priorities and needs we have for public funds it seems to be less than one of the best allocations, but I certainly understand that if I were a Member of Congress I certainly could see it differently.

Mr. Flood. Three hundred and eighty-five. "The Clerk will call the roll." Ever hear that?

Mr. Young. Yes, sir. I fully understand, sir.

NATIONAL INSTITUTE OF EDUCATION

Mr. Flood. National Institute of Education.

Mr. Young. Yes, sir.

Mr. Flood. You are asking for a $30 million increase for the National Institute of Education.

Mr. Young. That is correct, sir.

Mr. Flood. Increase over what?

Mr. Young. I am not sure what that base will be.

Mr. Flood. I don't doubt that.

Mr. Young. The Congress appropriated $75 million. Fortunately or unfortunately we came back and asked for a supplemental of $25 million. Obviously these numbers in this estimate assumes we had a $100 million base and we were requesting an additional $30 million.

LIBRARY RESOURCES

I might remark on the library resources, which are also of great interest to many Members of Congress, that we propose here to spend only $25 million for library services whereas in the past in the 1974 number you see, there is $49 million for local library services. The administration is proposing a phase down here.

Mr. Flood. You began by saying that many Members of Congress are interested in library resources.

Mr. Young. Yes.

Mr. Flood. So you are going to cut it $33 million.

Mr. Young. I said it was the case of another program where many Members of Congress have a deep and abiding interest.

Mr. Flood. However——

Mr. Young. However, the administration is proposing rather than spending $40 million for library resources at the local level, including operating expenses, only $25 million, which would be the beginning of a phasedown, leaving operation of libraries to the local jurisdictions on the basis that since 80-some percent of the American people now have reasonably adequate library services, the administration will also be proposing new legislation which will be accompanied by requested appropriations of $15 million to better utilize the existing library services by interchange, interconnection, and better regional use of existing services. That legislation hasn't yet been sent up.

Mr. Miller. Also, Mr. Chairman, last year we proposed to zero out the school library program. This year we are proposing the same amount as in fiscal year 1974 as part of the consolidated program. So our posture on libraries this year is much more on the up side than it was last year.

[Chart 9 follows:]

CONSOLIDATED EDUCATION GRANTS

[In millions of dollars]

	1974 enacted	1974 supplemental	1975 proposed
Elementary and secondary amendments:			
Disadvantaged (title I, ESEA)	1,719	1,885	1,900
Handicapped	48	48	50
Innovation	154	154	154
Supplementary services	146		
Other	8		
Support services	158	158	158
School libraries	90		
Equipment	29		
State departments of education	39		
Subtotal	2,077	2,245	2,262
Vocational education	533	544	550
State grants	495		
Research	38		
Adult education	63	63	63
State grants	53		
Special projects and training	10		
Total, consolidated grants	2,673	2,852	2,875

CONSOLIDATION OF EDUCATION GRANTS

Mr. YOUNG. I would like to go to chart 9. The purpose of this chart is merely to show the education grants that would be consolidated under the proposed advance funding of $2.872 billion. We would also, if legislation becomes available, advance fund vocational education and adult education. The authorization for adult education does not run out until 1975. It is also my understanding there may be hearings this year in the Congress on the proposed consolidation of vocational education.

I call attention to the bottom of chart 9 in the right-hand corner to the $2.875 billion. If these funds were appropriated to this amount, there would be [illegible] 79 million increase over our present authorized 1974 budget authority, an additional $23 million in 1975. Most of these additional funds would go into ESEA in title 1.

[Chart 10 follows:]

OTHER ELEMENTARY AND SECONDARY

[Budget authority in millions of dollars]

	1973	1974	1975	1975 change over 1974
Right to read	12	12	12	
Indian education	18	42	42	
Handicapped projects	107	100	100	
Bilingual	45	50	35	−15
Follow Through	58	41	35	−6
Educational broadcasting	20	19	14	−5
Career education	14		10	+10
Teacher Corps	38	38	38	
Other educational personnel	80	60	8	−52
Other ESEA	33	29	22	−7
Total, other ESEA	425	391	316	−75

OTHER ELEMENTARY AND SECONDARY EDUCATION

Mr. Young. I now turn to other elementary and secondary education, table 10.

I got to the line "Bilingual education" which indicates a proposed reduction of $15 million.

I would like to indicate at this time there may be a revision in these numbers based upon a recent court decision in California. So we may be coming forth with other numbers in this area. Is that a fair statement, Mr. Miller?

Mr. Miller. Yes, it is.

Mr. Young. The "Other educational personnel" line shows a proposed reduction of minus $52 million. This is because of the administration's feeling that the overall supply of teachers is adequate and we can now and in the future rely more on general student assistance, and also there is some specialized training in other parts of the budget. For instance, training of teachers of the handicapped for which there is an additional need. That is handled in the education budget.

[Chart 11 follows:]

HIGHER EDUCATION

[Budget authority in millions of dollars]

	1973	1974	1975	1975 change over 1974
Student assistance:				
Basic opportunity grants	122	475	1,300	+825
Work-study and cooperative education	281	281	261	−20
Supplemental opportunity grants	210	210		−210
Guaranteed loan subsidies and defaults	292	399	430	+31
Direct loans	562	293	6	−287
State incentive grants		19		−19
Subtotal	1,467	1,677	1,997	+320
Special programs for the disadvantaged	67	70	70	
Strengthening developing institutions	87	100	120	+20
Other higher education	116	110	42	−68
Total, higher education	1,737	1,957	2,229	+272

BASIC OPPORTUNITY GRANTS

Mr. Young. I would now like to move to table 11. The first item of interest here is the Basic Opportunity Grants which the administration proposes in 1975 for full funding: In other words, an increase over 1974 of $825 million.

This proposal would cover the full 4-years for these types of grants. As you will recall, the 1973 legislation provides for 1 year, 1974 for 2 years and the 1975 proposal is to cover all 4 years.

The $1.3 billion proposed in 1975 is considered to be full funding. In other words, the maximum amount in 1975 that a deserving student would get would be $1,400 compared to $450 in 1973 and $880 in 1974. The average grant under the basic opportunity grants program has been $260 in 1973, should be about $475 in 1974 and would rise to $700 per individual, on the average, in 1975.

We need to call to the attention of the committee the fact that in three of these areas the Congress has legislated statutory minimums that can be spent for various programs. The first one is the work-study and cooperative educational program, and the statutory minimum that has been legislated there is $237 million per year.

SUPPLEMENTARY OPPORTUNITY GRANTS

On the supplementary opportunity grants the statutory minimum is $130 million per year.

For direct loans the statutory minimum is $286 million.

If you add these three together there are statutory minimums of $653 million which the Congress has legislated.

The negative numbers you see under "1975 Change" column means that the administration again proposes to remove these statutory minimums.

In other words, supplemental opportunity grants are zeroed out and likewise, the direct loans.

WORK-STUDY AND COOPERATIVE EDUCATION PROGRAM

The work-study and cooperative education program is maintained at approximately the level that the Congress authorized in 1974.

I call your attention to the last line on this chart, other higher education, which indicates a proposal for a reduction of $68 million leaving a proposal of $42 million in 1975.

Some of the programs that would be reduced here are the university community service program aimed at helping universities help communities. The administration's view is that this hasn't been a very successful enterprise.

Also in this reduction is the veterans cost of instruction, and my understanding of the reason this is being deleted is because other types of assistance to veterans are being increased, and therefore there is no need for this program.

[Chart 12 follows:]

SOCIAL AND REHABILITATION SERVICE

[Budget authority in millions of dollars]

	1973	1974	1975	1975 change over 1974
Public assistance:				
Maintenance assistance	6, 311	5, 487	4, 398	−1, 089
Medical assistance (medicaid)	5, 761	5, 256	6, 537	+1, 281
Social services	1, 810	2, 000	2, 000	
State and local training	31	45	33	−12
Child welfare	46	47	46	−1
Research and training	17	17	9	−8
Subtotal	13, 976	12, 852	13, 023	+171
Work incentives	290	340	280	−60
Rehabilitation services	694	713	715	+2
Developmental disabilities	44	54	54	
Assistance to Cuban refugees	145	129	60	−69
Administration and other	62	62	74	+12
Total, SRS	15, 211	14, 150	14, 205	+55

SOCIAL AND REHABILITATION SERVICE

Mr. YOUNG. I would now move on to Social and Rehabilitation Service.

The first item I would like to talk about is maintenance assistance, in which you see a proposed reduction of over $1 billion from 1974 to 1975.

Now this decrease is the result of the transfer of the adult categories—aged, blind, and disabled—to the supplemental security income program. It is also due to the reduction in ineligibility and overpayment rates which the States are now taking the lead on with some assistance from HEW.

There also is a piece of proposed legislation that accounts for $203 million of the proposed reduction of $1 billion plus and that relates to proposed legislation on the earnings disregarded, which would change the manner in which aid to families with dependent children is compiled, the way you count income and the cost of day care.

INCOME DISREGARD LEGISLATION

If you wish, we could have Jim Moran place into the record an example of how that works because until this morning without an example I certainly did not understand it. If that would be useful, we could put a simple example in the record. And if you need further explanation, only Jim can do it because I have exhausted all I know now.

Mr. Flood. We will do that.

[The information follows:]

INCOME DISREGARD LEGISLATION

This proposed legislation would accomplish the following two things:

(1) Make it simpler for welfare workers to determine a person's eligibility for cash assistance.

(2) Eliminate people with relatively high incomes from participation in the aid for dependent children program.

The following example might help to explain how it would work. Take a welfare family with the following characteristics:

	Dollars per month
Earned income	$300
Income disregard (proposed $60)	30
Work expenses	40
Child care	50

	Currently	Proposed
Earned income	$300	$300
Income disregard	−30	−60
Net income	270	240
Less 1/3	−90	
Less child care	−50	−50
Less work expenses	−40	
Net income	90	190
Less 1/3		−63
Net income for purposes of determining eligibility for welfare payments	90	127

If enacted by July 1, 1974, this legislation will result in a savings of $203 million in the AFDC program.

MEDICAL ASSISTANCE

Mr. Young. In medical assistance (medicaid) here you notice the opposite of what we just saw, an inrcease of $1,281 million. $340 million of this over $1 billion increase is for the full-year cost to expand eligibility under the SSI program. $444 million of this proposed increase is a general increase in medical services costs and in the number of recipients. There also is included a net decrease of $55 million dependent on proposed legislation.

Also in these numbers, which the staff understood very well, there is a technical adjustment of a plus $552 million. This is the 1974 amount that was understated because the 1973 supplemental was used for 1974 costs.

There may be some question about the research and training line where there is a proposed reduction of $8 million. That decrease represents the termination of social work training grants on the basis that there are an adequate number of social workers.

The Cuban refugees program, where we propose a reduction of $69 million, is an item not heard by this committee.

[Chart 13 follows:]

SOCIAL SECURITY ADMINISTRATION

[In millions of dollars]

	1973	1974	1975	1975 change over 1974
Federal funds:				
Payment to trust funds	2, 389	3, 110	3, 345	+235
Special benefits to disabled coal miners	1, 520	1, 014	876	−138
Supplemental security income:				
Benefit payments		1, 644	3, 871	+2, 227
State supplementation		159	452	+293
Vocational rehabilitation services		40	54	+14
Administration	77	368	397	+29
Subtotal	77	2, 212	4, 774	+2, 562
Trust funds:				
Old-age survivors and disability insurance (receipts)	48, 783	58, 344	65, 184	+6, 840
Outlays	(48, 288)	(55, 258)	(64, 006)	(+8, 748)
Hospital and supplementary medical insurance (receipts)	11, 254	15, 477	16, 714	+1, 237
Outlays	(9, 479)	(12, 180)	(14, 191)	(+2, 011)
Administration (included in total above)	1, 327	1, 520	1, 647	+127

SOCIAL SECURITY ADMINISTRATION

Mr. YOUNG. Now I will move on to table 13, the Social Security Administration.

Let me just explain very briefly. I know the chairman and members of the committee understand this, but we may want it for the record.

Under the title "Federal Funds, Payment to the Trust Funds" you will note an increase of $235 million. This is an increase from general taxpayer receipts to the trust funds to cover, for instance, World War II veterans who were not paying into the trust fund.

SUPPLEMENTAL SECURITY INCOME

The next item of interest is the supplemental security income benefit payments. They increase by $2.227 billion. This is the full year costs, of which we only had partial costs in 1974.

It also accounts for an incease in benefits for SSI income recipients of 4 percent in the coming July.

The State supplementation of a proposed increase of $293 million is full-year costs as compared to this year where we have half-year costs. This is the hold harmless clause in the legislation so that no State will have to pay more than the 1972 base.

Going down to the trust funds, insurance receipts, you notice there is an increase of almost $7 billion there from 1974 to 1975. This primarily occurs because of the increase in the tax base from $10,800 to $13,200.

You also note in outlays there is an increase of almost $9 billion; $5.5 billion of this is for benefit increases, 4 percent in April and 7 percent in July of this year and $3.5 billion for growth in the eligible population.

Unless there are other questions on that we can go on to chart 14.

[Chart 14 follows:]

OFFICE OF HUMAN DEVELOPMENT

[Budget authority in millions of dollars]

	1973	1974	1975	1975 change over 1974
Child development:				
Head Start	392	392	430	+38
Research	13	15	16	+1
Youth development	10	10	15	+5
Programs for the aging:				
Community services	96	96	96	
Nutrition	100	100	100	
Research and training	15	17	7	−10
Native American programs	23	31	32	+1
Administration	24	25	29	+4
Total, OHD	672	685	724	+39

OFFICE OF HUMAN DEVELOPMENT

Mr. YOUNG. Office of Human Development. The first item of some interest is Head Start where we propose an increase of $38 million. Of this increase of $38 million, $16 million will be used for Head Start indirect administrative costs which have been provided, according to my understanding, by the Community Action Agencies presently funded by OEO. Also there is a $22 million general increase in Head Start because of increases in the costs of rendering these types of services.

The Head Start program will continue to serve approximately 380,000 children, 10 percent of whom are handicapped.

On youth development where there is a proposed increase of $5 million, this is primarily to be used to combat the problem of runaway youths—$3 million for grants for the youth centers under new legislation, $1 million for information services and $1 million for new youth service systems.

There is an item also here, research and training, under programs for the aged which shows a proposed minus $10 million. The reason is that there is $9.5 million available in 1974 funds that can be used in 1974 and 1975. So it is not a complete phaseout of that program as it looks.

Now in community services, under programs for the aging, the numbers proposed there will support about 300 planning and service areas that are already being established in 1974.

Under the proposed numbers you can increase the area planning agencies from 300 to 400. In other words, 300 should be in place this year and you can add an additional 100 with the proposed funds for 1975. The number of meals that would be served to the aged is approximately 200 meals per day, 5 days per week. Most of these meals are served at 665 project sites. Some few are delivered to their homes.

[Chart 15 follows:]

HEW EMPLOYMENT

	1973	1974	1975	1975 change over 1974
Full time permanent:				
Health agencies	43, 290	40, 197	41, 197	+1, 000
Education division	2, 904	3, 593	3, 679	+86
Social and Rehabilitation Service	2, 127	2, 414	2, 608	+194
Social Security Administration	61, 204	71, 665	72, 365	+700
Office of Human Development	731	939	939	
Office of the Secretary	4, 051	5, 092	5, 388	+296
Subtotal	114, 307	123, 900	126, 176	+2, 276
Other employment [1]	10, 845	7, 578	7, 764	+186
Total employment	125, 152	131, 478	133, 940	+2, 462

[1] Part time, temporary, intermittent.

HEW EMPLOYMENT

Mr. YOUNG. I now turn to chart 15, HEW employment.

I call your attention to the rather dramatic increase from 1973 to 1975 in terms of full-time employees. That increase is approximately 12,000 people.

Most of those have gone to the Social Security Administration to handle the new supplemental security income program and other social security legislation enacted during the past 2 years.

You also may be interested in where the increase in the Office of the Secretary occurs during that period: 290 or approximately 300 are for strengthening enforcement of civil rights laws, including the new provision of the Higher Education Amendments of 1972. Also there are approximately 450 additional positions to strengthen the regional offices to handle increased programs and administrative responsibilities.

In addition, there is an increase of 400 in the Food and Drug Administration for increased food and drug inspection.

ST. ELIZABETH HOSPITAL

There also is a proposed reduction of nearly 4,000 planned in 1974 if Congress approves our recommendation to transfer St. Elizabeth's Hospital to the District of Columbia.

Unless there are questions and we will go into this in greater detail later, I would like to stop. I certainly appreciate the indulgence of the chairman and members of the committee for this rather long rambling discussion.

RELEASE OF IMPOUNDED 1973 FUNDS

Mr. FLOOD. We know the Department has released the 1973 appropriations which were impounded. I assume this money will be obligated in fiscal year 1974 and fiscal year 1975 and that therefore those amounts actually available for obligation in those years for many,

many programs will be substantially higher than the amounts that you show on those charts. Is that right?

Mr. YOUNG. That is right because you have all of your funds in the 1973 column as authorized. But by court order and so forth those funds now fall into 1974. So you have the 1974 funds which were much larger than the administration proposed as I recall, plus the court ordered funds of 1973 and the release of impounded funds. So you have a very large bulge of funds in 1974.

Mr. FLOOD. What is the total amount of the impounded 1973 appropriations which you have released to date?

Mr. YOUNG. All 1973 funds that were impounded and ordered released by court order have been released, but they have not all been obligated. We can provide, as we have for other Members of the Congress and particularly the Senate, our plans for the obligation of those funds.

Mr. FLOOD. If I ask you how much is not going to be released, what are you going to say?

Mr. YOUNG. I would say none. Am I correct?

Mr. MORAN. Yes.

Mr. FLOOD. Will you insert for the record by program and list the amounts involved in the release of the 1973 impoundments and with how much will be obligated and spent in 1974, 1975 for each one?

Mr. YOUNG. Yes. sir.

[The following information was submitted:]

March 13, 1974

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Status of Obligations--1973 Released Funds
(Amounts in Thousands)

Appropriation/ Program	FY 1973 Impounded Appropriation	Obligation of Impounded Funds as of 1/31/74	FY 1973 Impounded Funds Not Yet Obligated As of 1/31/74	Explanation
A. HEALTH				
1. Mental Health:				
a.) Research	19,308	-	19,308	(To be obligated by June 30, 1974)
b.) Training	27,987	-	27,987	"
c.) Community Mental Health:				
(1) Staffing	40,000	40,000	-	
(2) Children	11,400	11,400	-	
(3) Construction	20,000	-	20,000	"
2. Alcoholism:				
a.) Research	4,700	-	4,700	"
b.) Training	5,400	-	5,400	"
c.) Community Programs:				
(1) Project grants	39,309	-	39,309	"
(2) Formula grants	30,000	-	30,000	"
3. Health Services Planning and Development:				
a.) HS Research and Development	12,843	-	12,843	"
b.) Comprehensive Health planning	6,450	-	6,450	"
c.) Regional medical programs	89,811	-	89,811	(Will be obligated in FY 1975)
d.) Medical Facilities Construction	195,200	-	195,200	(To be obligated by June 30, 1975)
4. Health Services Delivery:				
a.) Comprehensive Health Services project grants	6,000	-	6,000	(To be obligated by June 30, 1974)
b.) Maternal and Child Health project grants	(10,472)	(To be reprogrammed to Formula grants)		
c.) Family Planning grants/contracts	30,409	-	30,409	"
5. Preventive Health:				
a.) CDC project grants/contracts	7,225	-	7,225	"
b.) Community Environmental Management grants	4,500	-	4,500	"
c.) Occupational Health project grants/contracts	4,257	-	4,257	"

(CONT)

Appropriation/Program	FY 1973 Impounded Appropriation	Obligation of Impounded Funds as of 1/31/74	FY 1973 Impounded Funds Not Yet Obligated As of 1/31/74	Explanation
6. NIH-Research, Training, and Fellowship grants/contracts:				
a.) NCI	58,859 1/	776	58,083	(To be obligated by June 30, 1974)
b.) NHLI	44,217 2/	5,997	38,220	"
c.) NIDR	6,112	1,154	4,958	"
d.) NIAMDD	24,043	8,679	15,364	"
e.) NINDS	22,741	22,147	594	"
f.) NIAID	10,392	4,169	6,223	"
g.) NIGMS	28,966	5,299	23,667	"
h.) NICHD	19,033	4,233	14,800	"
i.) NEI	4,120	1,170	2,950	"
j.) NIEHS	4,736	372	4,364	"
k.) Research Resources	2,155	-	2,155	"
l.) FIC	709	-	709	"
7. Health Manpower:				
a.) Health Professions capitation	13,700	9,900	3,800	"
b.) Start-up grants	5,700	-	5,700	"
c.) Financial distress/Special project grants	28,600	23,100	5,500	"
d.) Health Professions Construction	100,000	6,000	94,000	"
e.) Dental Health activities	2,000	-	2,000	"
f.) Health Professions Educational Activities	11,000	-	11,000	"
g.) Nursing Support:				
(1) Start-up grants	2,000	-	2,000	"
(2) Distress grants	9,830	-	9,830	"
(3) Special project grants	10,170	-	10,170	"
(4) Student Assistance	5,000	-	5,000	"
(5) Educational Assistance	4,150	-	4,150	"
(6) Construction grants	20,000	-	20,000	"
(7) Capitation	21,700	21,700	-	

1/ Includes contracts ($16,909,000)

2/ Includes contracts ($14,000,000)

(CONT)

Appropriation/Program	FY 1973 Impounded Appropriation	Obligation of Impounded Funds as of 1/31/74	FY 1973 Impounded Funds Not Yet Obligated As of 1/31/74	Explanation
h.) Public Health Support..................	6,660	-	6,660	(To be obligated by June 30, 1974)
i.) Allied Health Support..................	16,000	-	16,000	"
j.) Special Education programs.............	38,600	-	38,600	"
8. National Library of Medicine................	3,338	-	3,338	"
Total, Health.................	1,079,330	166,096	913,234	
B. EDUCATION:				
1. Elementary and Secondary:				
a.) Educationally deprived.................	224,815	224,815	-	
b.) Supplementary services.................	25,000	25,000	-	
c.) Stregthening State Dept. of Education:				
(1) general support................ ..	10,000	10,000	-	
(2) evaluation..................... ...	5,036	5,036	-	
d.) Equipment and minor remodeling.........	48,000	48,000	-	
e.) Bilingual Education....................	9,870	-	9,870	"
2. SAFAA Construction	10,000	-	10,000	"
3. Education for the handicapped .... (project grants)	12,500	12,500 3/		
4. Vocational Education:				
a.) State grants...........................	50,000	50,000	-	
b.) Special needs..........................	9,898	9,898	-	
c.) Consumer...............................	12,697	12,697	-	
d.) Work-study.............................	4,524	4,524	-	
e.) State advisory councils................	514	-	514	"
f.) Curriculum development.................	2,000	-	2,000	"
5. Adult Education.............................	23,700	23,700	-	

3/ The $12,500,000 was actually obligated 9/4/73 as a contingent obligation in the State Grant Program. If the court rules that the funds should be used for discretionary project grants, awards will be made.

(CONT)

Appropriation/Program	FY 1973 Impounded Appropriation	Obligation of Impounded Funds as of 1/31/74	FY 1973 Impounded Funds Not Yet Obligated As of 1/31/74	Explanation
6. Library Resources:				
a.) Public Libraries:				
(1) Services	36,770	36,770	-	
(2) Construction	15,000	15,000	-	
b.) School Libraries	10,000	10,000	-	
c.) Undergraduate instructional equipment	12,500	189	12,311	(To be obligated by June 30, 1974)
7. Education Development:				
a.) Sesame Street	1,000	-	1,000	"
b.) Environmental Education	820	-	820	"
c.) Nutrition/Health	500	-	500	"
d.) Dropout prevention	1,500	-	1,500	"
e.) Educational statistics	2,650	-	2,650	"
f.) National Achievement study	1,000	-	1,000	"
Total, Education	530,294	488,129	42,165	
Total	1,609,624	654,225	955,399	

RESERVES

Mr. **Flood**. How much of the 1974 appropriations are currently placed in what you call the reserve? We want a list of them along with an explanation of the reason for the reserve in each case for the record.

Mr. **Young**. Yes. We have to report that to the Congress under the Humphrey Act.

Mr. **Flood**. But put it in the record.

[The information follows:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Appropriations and Reserves, Fiscal Year 1974

Public Health Service

Appropriation title	1974 appropriation	Formal reserves			Total reserves	Explanation
		Savings	For obligation in subsequent years	For other contingencies		
Mental health................	$815,975,000			$22,762,000	$22,762,000	The column "Other Contingencies" includes $136,601,000 not available as a result of the $400,000,000 reduction authorized by P.L. 93-192. Of this amount $26,170,000 is for transfer for pay increases costs.
Health services planning and development................	386,520,000			16,691,000	16,691,000	
Health services delivery.....	853,280,000		$2,250,000		2,250,000	
Indian health facilities.....	49,927,000		88,000		88,000	Reserves are released as projects are approved. This reserve figure is from prior year money.
National Cancer Institute....	551,191,500			23,705,500	23,705,500	Savings withheld from obligation and expenditure (Public Law 93-192).
National Heart and Lung Institute..................	302,915,000			13,365,500	13,365,500	
National Institute of Dental Research............	45,365,500			1,606,500	1,606,500	
National Institute of Arthritis, Metabolism, and Digestive Diseases.........	159,447,000			6,486,000	6,486,000	
National Institute of Neurological Diseases and Stroke.................	125,000,000			5,042,000	5,042,000	
National Institute of Allergy and Infectious Diseases....	114,000,000			3,596,000	3,596,000	
National Institute of General Medical Sciences...........	176,778,000			8,449,000	8,449,000	

Appropriation title	1974 appropriation	Formal reserves Savings	For obligation in subsequent years	For other contingencies	Total reserves	Explanation
National Institute of Child Health and Human Development................	130,254,000			5,357,000	5,357,000	Savings withheld from obligation and expenditure (P.L. 93-192).
National Eye Institute.......	41,631,000			1,684,000	1,684,000	
National Institute of Environmental Health Sciences.....	28,879,000			482,000	482,000	
Research Resources...........	133,472,000			6,531,000	6,531,000	
Health Manpower..............	642,335,512			20,844,000	20,844,000	
Buildings and facilities, NIH........................	8,000,000		14,021,111		14,021,111	Reserves are released as projects are approved. Reserves include $5,980,000 of 1974 money and $8,041,111 of prior year money.
Scientific Activities Overseas...................	1,912,000		21,714,000		21,714,000	Reserve for subsequent apportionment.
Total.............			38,073,111	136,601,000	174,674,111	

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Office of Education
Appropriations and Reserves, Fiscal Year 1974

Appropriation Title	1974 Appropriation	Formal Reserves			Total Reserves	Explanation
		Savings	For Obligations in Subsequent Years	For Other Contingencies		
Elementary and Secondary Education....................	2,121,893,000	—	—	96,725,000	96,725,000	Savings withheld from obligation and expenditure (Public Law 92-192) For other contingencies represents money transfered for "Special benefits for disabled coal miners".
School Assistance in Federally Affected Areas.......	610,000,000	—	—	16,584,000	16,584,000	Savings withheld from obligation and expenditure (Public Law 93-192).
Education for the Handicapped..	152,404,000	—	—	5,325,000	5,325,000	Savings withheld from obligation and expenditure (Public Law 93-192).
Higher Education	1,889,414,000	---	---	29,167,000	29,167,000	Savings withheld from obligation and expenditure (P.L. 93-192).
Library Resources..............	171,709,000	—	—	8,585,000	8,585,000	Savings P.L. 93-192 to lapse. Other contingencies represents transfer for pay raise.
Occupational, Vocational, and Adult Education..............	614,903,000	—	—	26,354,000	26,354,000	Savings P.L. 93-192 to lapse.
Educational Development........	157,170,000	—	—	4,487,000	4,487,000	Savings P.L. 93-192 to lapse.
Salaries and Expenses..........	86,747,000	—	—	319,000	319,[illegible]	Savings P.L. 93-192 to lapse. Other contingencies transfer to Office of Secretary for public affairs reduction.
Total, Office of Education...........	5,804,240,000			187,546,000	187,546,000	

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Social and Rehabilitation Service
Appropriations and Reserves, Fiscal Year 1974

Appropriation Title	1974 Appropriation 1/	Formal Reserves Savings	For Obligations in Subsequent Years	For Other Contingencies	Total Reserves	Explanation
Grants to States for public assistance..........	$12,854,471,000	---	---	$2,950,000	$2,950,000	The column "For other contingencies" includes $4,575,000 of funds not available as a result of the $400,000,000 reduction authorized by Public Law 93-192
Social and Rehabilitation Services..................	768,518,000	---	---	1,625,000	1,625,000	
Total, Social and Rehabilitation Services..	$13,622,989,000	---	---	$4,575,000	$4,575,000	

1/ Adjusted for comparability to '75 budget request.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Social Security Administration
Appropriations and Reserves, Fiscal Year 1974

Appropriation Title	1974 Appropriation	Formal Reserves Savings	For Obligations in Subsequent Years	For Other Contingencies	Total Reserves	Explanation
Limitation on Construction (Trust Fund)................	---	---	$15,393,497	---	$15,393,497	No year appropriation available until expended. Amount in reserve is for obligation in subsequent years.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Appropriations and Reserves, Fiscal Year 1974

SPECIAL INSTITUTIONS

Appropriation Title	1974 appropriation	Formal reserves			Total reserves	Explanation
		Savings	For obligation in subsequent years	For other contingencies		
Howard University: Construction	---	---	$ 11,490,154	---	$ 11,490,154	Held in reserve pending development of plans for obligation of construction funds.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Office of Human Development
Appropriations and Reserves, Fiscal Year 1974

Appropriation Title	1974 Appropriation	Formal Reserves			Total Reserves	Explanation
		Savings	For Obligations in Subsequent Years	For Other Contingencies		
Child Development............	$434,600,000	---	---	$15,500,000	$15,500,000	Formal reserves are in accordance with PL 93-192, and include from the Head Start activity 1) savings of $9,020,000 unapportioned; and 2) $6,480,000 transferred to Departmental Management to cover cost of pay raises.

DISCREPANCY IN EMPLOYMENT FIGURES

Mr. FLOOD. Last year Mr. Cardwell gave us a familiar chart talk on the 1974 budget, and he also had a chart on employment. His chart showed 119,304 employees in HEW for 1973 and 116,672 employees in 1974.

Your chart shows 125,152 employees in 1973 and 131,478 in 1974. In other words, your figures are higher by 6,000 in 1973 and by 15,000 in 1974. Can you explain where these people came from?

Mr. YOUNG. That difference is partly accounted for by the 5,000 positions for the Public Health Service hospitals that don't show in the 1974 tables since we proposed to close down the hospitals at that time. The rest of increases I believe can be accounted for by the restoration of programs we proposed to phase out or consolidate. If I am not correct on that, I will find the answer.

Mr. FLOOD. If you are not you had better.

You are still proposing the transfer of St. Elizabeth's Hospital to the District of Columbia, aren't you?

Mr. YOUNG. Yes, sir.

Mr. FLOOD. How many employees at St. Elizabeth's Hospital are included in the chart for each one of those 3 years you showed us?

Mr. COOK. 4,000 in 1973. None in 1974 or 1975.

Mr. FLOOD. How many positions are included in each of the 3 years for the Public Health Service hospitals?

Mr. YOUNG. The employees on board have decreased: 5,152 in 1973; 4,990 in 1975; and 4,950 in 1975; however, as I stated before the patient-staff ratio is increasing.

HEALTH AGENCY EMPLOYMENT

Mr. FLOOD. Also for the record, break down by agency the employment figures shown for what you call the health agencies.

Mr. YOUNG. Yes, sir. Do you want the numbers for 1973, 1974, and 1975?

Mr. FLOOD. Yes.

[The information follows:]

HEALTH: FULL-TIME EMPLOYMENT IN PERMANENT POSITIONS

	Actual, onboard, 1973	Estimated, 1974	Estimated, 1975
OASH[1]		1, 260	1, 435
FDA	6, 149	6, 324	5, 482
HSMHA[2]	25, 569		
HSA		15, 330	15, 743
HRA		1, 963	2, 018
CDC		3, 520	3, 580
NIH	11, 247	10, 395	10, 459
ADAMHA		1, 405	1, 480
Total	42, 965	40, 197	41, 197

[1] Includes service and supply fund.
[2] Includes St. Elizabeths Hospital.

OFFICE OF THE SECRETARY EMPLOYMENT

Mr. FLOOD. How do you account for this enormous increase? You have an increase of 1,337 employees between 1973 and 1975 in the Office of the Secretary.

Mr. YOUNG. There are about 300 of those for additional enforcement of civil rights laws, including the new provision of the Higher Education Amendments of 1972. There are also 450 positions most of which are in the working capital fund for strengthening the 10 regional offices. Can you think of other places?

Mr. COOK. There is another 580 positions of which about 50 were included in a supplemental to implement the higher education amendments, about 140 for H.R. 1, 135 new positions in the 1975 budget request, about 100 positions transferred from Office of Economic Opportunity, and 80 positions transferred from Social Security Administration for the Office of General Counsel for Black Lung.

PROGRAMS REQUIRING NEW AUTHORIZATION IN 1975

Mr. FLOOD. How much of the 1975 budget for Health, Education, and Welfare lacks authorization? In other words, what we want now is a list of the programs for which there is no law, which lack authorization.

Mr. YOUNG. I have that exhibit.

Mr. FLOOD. Put it in the record with the amount included in the budget for each one of them, and identify the name and the number of the bills which provide the necessary authorization.

Mr. YOUNG. We have all of that. I don't think we have the number of bills. We will provide that.

[The following information was provided:]

ANALYSIS OF LEGISLATIVE PROGRAM

Program/Legislation	Description/ Treatment in Budget
Health Services	
Expiring:	
Comprehensive health grants to States (Sec. 314(d), PHS Act)	To be included in the Health Services Amendments of 1974
Community health centers (Sec. 314(e), PHS Act)	To be included in the Health Services Amendments of 1974.
Maternal and child health project grants (Sec. 502, Social Security Act)	Not extended. To be included in Formula grants.
Family planning (Title X, PHS Act)	To be included in the Health Services Amendments of 1974.
Migrant health (Sec. 310, PHS Act)	To be included in the Health Services Amendments of 1974.
National health service corps. (Sec. 329, PHS Act)	Extended
Preventive health services	
Expiring:	
Rat control (Sec 314(e), PHS Act)	To be included in the Health Services Amendments of 1974.
National Institutes of Health	
Expiring:	
(Contract authority) (Sec. 301 (h), PHS Act)	Extended
National Cancer Institute (National Cancer Act of 1971)	Extended

Program/Legislation	Description/ Treatment in Budget
Alcohol, drug abuse and mental health	
Expiring:	
Alcoholism project grants (Sec. 246 and 247, CMHC Act)	To be included in Health Services Amendments of 1974
Alcoholism grants to States (Sec.301, Comprehensive Alcohol Abuse Act)	Extended
New legislation:	
Payment for St. Elizabeths Hospital, $42,340,000	Transfer of hospital to District of Columbia.
Health Resources	
Expiring:	
National health statistics (Sec. 305, PHS Act)	Extended
Comprehensive health planning (Sec. 314, PHS Act)	Not extended. Areawide planning function to be included in proposed health planning legislation.
Regional medical programs (Title IX, PHS Act)	Not extended. Planning function to be included in proposed health planning legislation.
Health services research and evaluation (Sec. 304, PHS Act)	Extended
Health manpower	
Nurse Training Act (Title VIII, PHS Act)	Not extended. Scholarship and special project authorities to be included in extension of Comprehensive Health Manpower Training Act.
Public Health Training Act (Sec. 306, PHS Act)	Not extended. Authority for special project to be included in extension of Comprehensive Health Manpower Training Act.
Allied Health Training Act (Title VII, part G, PHS Act)	Not extended. Authority for special projects to be included in extension of Comprehensive Health Manpower Training Act.
Comprehensive Health Manpower Training Act (Title VII, PHS Act)	Extended. New legislation to included certain activities previously funded under the above three acts.

Program/Legislation	Description/ Treatment in Budget
Health resources (con'd)	
Medical facilities construction (Title VI, PHS Act)	Not extended.
Health teaching facilities (Title VII and VIII, PHS Act)	Not extended.
New legislation:	
Health resources planning $66,500,000	Would provide funds to States for health regulatory and planning activities and to regional planning bodies. Partially replaces functions previously under comprehensive health planning and Regional medical programs.
National Health Service Corps Scholarships, $19,500,000	Authorizes scholarships to students in health professions in exchange for specified periods of service as the Secretary may prescribe.
Elementary and Secondary education	
Expiring:	
Educationally deprived children (Title I, ESEA Act)	To be included in Education grants consolidation
Supplementary services (Title I, ESE Act)	To be included in Education grants consolidation.
Strengthening State departments of education (Title I, ESE Act)	To be included in Education grants consolidation.
Bilingual education (Title VII, ESE Act)	Extended, new legislation.
Follow-through (Sec. 222 (a)(1) EO Act)	Extended, new legislation.
Environmental education (Environmental Education Act)	To be included in Education grants consolidation.
Nutrition and health (Sec. 808, ESE Act)	To be included in Education grants consolidation.

Program/Legislation	Description/ Treatment in Budget
Elementary and secondary education (Cont)	
New legislation:	
Education grants consolidation, $2,875,485,000	Provides for grants in six broad functional areas. Aim is to eliminate overlapping and unnecessarly narrow categorical programs.
School assistance in Federally affected areas	
Expiring:	
Payments for "B" children (P.L. 874)	Not extended ($40 million phase out "cushion" in budget).
Special provisions (P.L. 874)	Extended.
Construction (P.L. 815)	Extended.
Emergency School Aid Expiring:	Additional extension legislation proposed for special projects.
Education for the handicapped	
Expiring:	
State grant program	To be included in Education grants consolidation.
Other handicapped programs	Extended, new legislation.
Occupational, vocational and adult education	
Expiring:	
Adult education (Adult Education Act)	To be included in Education grants consolidation.
Dropout prevention (Sec 807, ESEA Act)	To be included in Education grants consolidation
Ethnic heritage studies (Title IX, ESEA Act)	Not extended
Higher education	
Expiring:	
Insured loan subsidies (Emergency Insured Student Loan Act)	Extended, new legislation

Program/Legislation	Description/ Treatment in Budget
Library resources	
Expiring:	
School library resources	To be included in Education grants consolidation
New legislation:	
Library partnership, $15,000,000	Change of Federal role away from general formula grants to a project grant approach which will focus on specific populations (e.g. disadvantaged) and on innovative activities.
Public assistance	
New legislation:	
Public assistance maintenance assistance, -$203,000,000	Savings resulting from nationwide uniform application of income disregard in calculation of benefits.
Medical assistance,-$75,000,000	Savings resulting from elimination of Federal matching payments for adult dental care, execpt emergency services.
Medical assistance, $20,000,000	Provide for reimbursement for services received by Medicaid receipents at free-standing clinics.
Rehabilitation service	
Expiring:	
Grants for the developmentally disabled	Extended
Human development	
Expiring:	
Head start, (Sec. 222 (a) EO Act)	Extended, new legislation
Youth development (J.D.P. Act)	Extended
Aging nutrition (Title VII, Old American Act)	Extended
Special programs for Native Americans (Sec. 222, OEO Act)	Extended, new legislation
Departmental Management	
Expiring:	
Policy research, (Sec.232,EO Act)	Extended, new legislation
New legislation:	
Phase-out of OEO activities, $33,000,000	Provide for transfer of residual OEO activities for phase out. Funds would be used for salaries and expenses and for contingent grant and contract obligations.
Allied services, $20,000,000	Provide funds for demonstration projects to develop the concept of intergrated service delivery at the local level.

Mr. FLOOD. Mr. Patten.

1975 BUDGET PROPOSALS

Mr. PATTEN. This is the first glance I have had at your proposed budget. Do I understand the Secretary will be here tomorrow?

Mr. YOUNG. Yes, sir.

Mr. PATTEN. This is your first exposure to what will be many hundreds of hours we will spend here. I wouldn't know where to start.

When you speak of cutting out library services and cutting out my wonderful medical research projects and some of these other programs, it makes me wonder if best judgment is being used.

Mr. YOUNG. I understand your concern, sir.

Mr. PATTEN. For instance, let's take one of the two programs where we are putting in an enormous amount of money. Let's take the cancer program of $600 million.

It was my pleasure to sit here and vote over $500 million last year. Yet my School of Microbiology at Rutgers claims under the guidelines they are not getting any help. They have wonderful people who have proven their worth. This is a school that was built on streptomycin, by the wonderful Dr. Wakesman.

I am just thrilled to think we have streptomycin to help people. They tell me it saves the lives of at least a million people every year just in the field of pneumonia. TB hospitals are empty.

Mr. YOUNG. Is that Johnson and Johnson?

Mr. PATTEN. Yes. It is terrific. Yet they tell you there isn't one pharmaceutical in Vietnam.

The President of Cameroon tells me he is an old man in his country at 38. Half of the children born die before they are 1 year old, and how they would like to have some polio vaccine and streptomycin and penicillin.

I think what our research people have done in my lifetime in some of these areas, you might even include meningitis, is terrific and has been a good investment.

The people in the microbiology building claim their applications for some of the cancer funds have not been granted. They are crushed. If you take the other research programs where they have good leads, it is hard to sit here and figure we are going to cut them off.

Mr. YOUNG. These are predoctoral students I take it, Mr. Patten?

Mr. PATTEN. Yes. I am afraid there might be a big question of whether fellowships, and other grants will survive.

I would like to look at this budget without the Social Security money in it so I can make a more adequate comparison with previous years of the programs, but I know I am not going to get that today.

Mr. YOUNG. I think, sir, in what we call the all purpose tables and in all of the tables that I have talked about today the social security funds are separated from all other funds. The chairman has also asked for some additional tables to be presented which we will do. There is no reason that can't be done so that you can focus on the Federal funds and disregard the social security funds. That can be done. Your staff has the numbers and if they don't have what they need and you need, we will provide it.

Mr. PATTEN. I said at the outset I didn't want to get started on this. We will probably have time when the more detailed presentation is made.

There is only one area I agree with you—impacted aid. I always vote against impacted aid because I recognize the inequities as far as my district goes. But that is futile. I know the vote on the floor for impacted aid. But I can give the argument the administration gives. But in many other programs I think a great deal will be said before we get this bill on the floor.

Mr. FLOOD. We will adjourn until 10 tomorrow.

TUESDAY, MARCH 19, 1974.

SECRETARY OF HEALTH, EDUCATION, AND WELFARE

WITNESSES

HON. CASPAR W. WEINBERGER, SECRETARY
FRANK C. CARLUCCI, UNDER SECRETARY
JOHN D. YOUNG, ASSISTANT SECRETARY, COMPTROLLER
STEPHEN KURZMAN, ASSISTANT SECRETARY FOR LEGISLATION
CHARLES MILLER, DEPUTY ASSISTANT SECRETARY, BUDGET

Mr. FLOOD. Now we have the pleasure and privilege of the presentation of the Department of Health, Education, and Welfare, the overview of the 1975 budget. The presentation will be made by Caspar W. Weinberger, the Secretary.

We are glad to have you in our new surroundings. We made a point to the other witnesses who appeared before that the intimacy of the way we ran the hearings in the other room is not going to change because of this arm's length business.

We will place in the record a biographical sketch of you and Secretary Carlucci.

[The biographical sketches follow:]

HON. CASPAR W. WEINBERGER, SECRETARY OF HEALTH, EDUCATION, AND WELFARE

Caspar W. Weinberger became the Nation's 10th Secretary of Health, Education, and Welfare on February 12, 1973. He was nominated for the post by President Nixon on November 28, 1972, and took the oath of office at San Clemente, Calif., his home State.

He is also responsible for the development, implementation and coordination of Federal policy in the human resources area.

Secretary Weinberger has served in the Nixon administration since January 13, 1970, when he became Chairman of the Federal Trade Commission. After 7 months in this assignment, he moved to the newly created Office of Management and Budget as Deputy Director. He assumed the leadership of OMB on June 12, 1972, serving as Director, until he was sworn in as HEW Secretray.

Born in San Francisco August 18, 1917, Secretary Weinberger attended public schools there. He was graduated magna cum laude from Harvard College in 1938 where he was elected to Phi Beta Kappa. He received his bachelor of laws degree from Harvard Law School in 1941.

Shortly after his graduation from law school, Secretary Weinberger entered the Army as an infantry private. He served more than 3 years in the Pacific with the 41st Infantry Division and as a member of General Douglas MacArthur's intelligence staff. He was discharged in 1945 as a captain.

Following his wartime service, the Secretary spent 2 years as law clerk to Federal Judge William E. Orr of the U.S. Court of Appeals for the Ninth Circuit. He then entered private practice.

In 1952, while in private law practice, he was elected to the Assembly of the California State legislature from the 21st District in San Francisco. He won reelection without opposition in 1954 and 1956.

During his years in the California Legislature, Secretary Weinberger was chairman of both the assembly committee on government organization and the joint assembly-Senate subcommittee on alcoholic beverage control. His leadership produced a constitutional amendment reorganizing the State's alcoholic beverage control machinery, and the creation of a unified department of water resources.

Newsmen covering the 1955 legislative session in California named the Secretary as the most able member of the State legislature.

From 1959 to 1968, Secretary Weinberger pursued simultaneous careers as a lawyer, writer, and television moderator. He was a partner in the San Francisco law firm of Heller, Ehrman, White, and McAuliffe, and wrote a twice-weekly column on California State government carried in many State newspapers. He also reviewed books for the San Francisco Chronicle and San Francisco magazine, and moderated a weekly public affairs television show, "Profile: Bay Area," on KQED-TV, the San Francisco educational television station.

Secretary Weinberger headed the Commission on California State government and organization—known as the State's "Little Hoover Commission"—from 1967 to 1968. On February 1, 1968, he was named State director of finance by Governor Ronald Reagan, serving in the post until he left for Washington to Chair the Federal Trade Commission.

Secretary Weinberger is married to the former Jane Dalton. They are the parents of two children, a daughter and a son.

FRANK C. CARLUCCI, UNDER SECRETARY

President Nixon nominated Frank C. Carlucci as Under Secretary of Health, Education, and Welfare in December 1972.

Sworn in a month later, Carlucci began the formidable task of helping Secretary Weinberger run HEW, a sprawling human resources agency with 250 different programs and a projected 1974 budget of nearly $94 billion.

He brings to these responsibilities a depth of high-level experience and notable achievements in the Foreign Service in top-level Washington assignments.

Just before coming to HEW, Carlucci served for a year and a half in the Office of Management and Budget, first as Associate Director and later as Deputy Director. While serving at OMB in August 1972 he was sent by the President as his personal representative to Wilkes-Barre, Pa., where he coordinated Federal relief efforts for flood-stricken victims of Tropical Storm Agnes, the largest natural disaster in our country's history.

Prior to his stint at OMB, Carlucci was Director of the Office of Economic Opportunity from January to September 1971.

Before his Washington assignments, Carlucci spent 14 years in the Foreign Service, where he continues to maintain career status.

In his second overseas assignment, Carlucci served as Second Secretary and Political Officer at Kinshasa in the Congo. He assumed this post in 1960 when the Congo had won its independence from Belgium, an event which sparked bloody political upheavels. Carlucci's sensitive and courageous handling of explosive situations there won him the Department of State's Superior Service Award in 1962 "for * * * his outstanding courage in the face of real danger * * * and * * * his resourcefulness and effectiveness as a political reporting officer."

From 1964 to 1965, he served as Chargé d'Affaires, then Consul General in Zanzibar, a newly independent and leftward leaning African state in political tumult.

Carlucci's next assignment abroad was in Rio de Janeiro, where he served as Counselor for Political Affairs. While there, he earned the Department's Superior Honor Award for his administrative skill in organizing a more cohesive and effective embassy staff.

Carlucci was born in Scranton, Pa., on October 18, 1930. He was graduated from Princeton University in 1952 and attended the Harvard University graduate school of business for 1 year. From 1952 to 1954, he served as an officer in the U.S. Navy and from 1955 to 1956, he was in private business with the Jantzen Co. in Portland, Oreg.

He and his wife reside in Washington, D.C., with their two chidlren.

Secretary WEINBERGER. The Under Secretary, of course, accompanies me this morning, Frank Carlucci, and Mr. Jack Young, comptroller of the Department, Stephen Kurzman, Assistant Secretary for Legislation, and Charles Miller, Deputy Assistant Secretary, Budget.

Mr. FLOOD. If there is anybody on the staff you want to call on, do that. Also, our practice is if they wish to volunteer it is all right for them to do so and then give us their name, and then we insert a short biographical sketch of them. In case the staff wants to sound off about something hot, it is not necessary for the boss to turn around and call on them. We prefer it that way.

GENERAL STATEMENT

Mr. Secretary, I see you have a prepared statement. How do you wish to proceed?

Secretary **WEINBERGER**. I could read it quickly or put it into the record and go to the questions.

Mr. **FLOOD**. It is your show.

Secretary **WEINBERGER**. I would read it then, if I may.

Mr. **FLOOD**. You may proceed.

Secretary **WEINBERGER**. Mr. Chairman and members of the committee. It is a pleasure to appear before you to present the Department's 1975 budget request.

The 1975 HEW budget proposes total spending of $111 billion, an increase of $14.3 billion over our current estimate for 1974. In budget authority our request is up $10.1 billion over 1974 to a total of $114 billion. Once again, the HEW share of the Federal budget has increased until it now stands at 36.5 percent, more than a third of the entire Federal budget.

The bulk of the $14.3 billion increase in outlays occurs in noncontrollable programs, principally social security benefits which, including medicare, are up about $10.6 billion and supplemental security income, which requires a net increase of $1.5 billion for its first full year of operation. This growth is the result of larger beneficiary populations, substantially increased benefit levels and eligibility voted by Congress last year, and higher medical costs.

The Department's overall employment is expected to reach 126,000 full-time, permanent employees in 1975. This is 12,000 more than were on duty at the end of fiscal year 1973. The largest factor in this increase is the addition of 11,000 employees to administer the supplemental security income program and implement other social security amendments. Despite this overall increase, we are making every effort to hold down Federal employment to the absolute minimum needed to carry out the Department's responsibilities. I might add, Mr. Chairman, that had the various savings and program terminations we suggested last year been put in effect, we would have saved approximately $2 billion and probably would have needed approximately 7,000 fewer employees. Since those savings were not adopted, the overall spending and employment totals of the Department have risen substantially.

I would like to provide an overview of the HEW budget in terms of four categories which, I believe, place our programs in perspective:

Financial assistance to families and individuals increases the income of persons through cash transfer programs and, through earmarked financial assistance, enables individuals to obtain education and health care. This is the largest area of growth in the HEW budget, increasing $13.7 billion in 1975 to $96.6 billion.

Financial assistance to States and localities increases their ability to provide human services. Within broad national priorities, States and localities can and should be free to assess their particular needs and devise effective systems for delivering services to their communities. In this category spending will increase $40 million to $9.3 billion.

Developmental activities include research and development in areas of vital national concern, especially medicine and education, skilled manpower training to meet critical shortages and upgrade skills, and demonstrations and dissemination to get the results of our research into practice. Spending in this category will reach $4.4 billion in 1975.

Effective management insures that the public gets maximum value for its tax dollars.

FINANCIAL ASSISTANCE TO FAMILIES AND INDIVIDUALS

At the heart of the Department's mission is the goal of insuring that all Americans have at least a minimum standard of living so that they can develop their full potential. Programs which provide direct financial assistance to individuals are the primary vehicles for achieving that goal. These programs meet essential human needs quickly, efficiently, and equitably. More importantly, direct financial assistance allows each individual to decide for himself which goods and services are appropriate for his situation.

As in past years, the vast majority of our budget is for aid to families and individuals. In fact, of the $111 billion in 1975 outlays in the HEW budget, $97 billion, or 87 percent, is for financial assistance programs. This is an increase of $13.7 billion and, of course, includes both Federal funds and trust funds.

Even when trust funds are removed, financial assistance programs make up more than half of our budget. Of the $34.7 billion in appropriation requests which will be considered by this subcommittee, $20.5 billion is for financial assistance programs.

CASH PAYMENTS

Direct cash payments to families and individuals are made from trust funds for the old-age, survivors, and disability insurance program and from Federal funds for the supplemental security income, disabled coal miners, and maintenance assistance programs. The 1975 budget includes a $10.2 billion increase in the cost of these programs. The principal factors in this increase are the two-step, 11-percent increase in social security cash benefits authorized by Congress last December and expansion of the number of people receiving assistance, especially the aged and disabled.

The newest financial assistance program is supplemental security income, initiated January 1, 1974. It replaces the State-administered programs of aid to the aged, blind, and disabled, with a Federal program based on uniform eligibility requirements and basic payment levels throughout the country. When the program began, 3.2 million people received benefits, nearly all of them converted from the prior State systems. Claims from newly eligible people under the broadened definition of the Congress have been lower than originally expected. The Social Security Administration has begun an intensive effort to make sure that all eligible persons are aware of this new entitlement and are given an opportunity to claim their benefits. The 1975 budget assumes that by the end of 1975 about 80 percent of the estimated 7 million eligibles, or 5.6 million people, will be receiving benefits.

The shift of the aged and disabled to SSI leaves the maintenance assistance category of public assistance composed primarily of aid to families with dependent children. Our request for the AFDC program in 1973 of $3.9 billion is predicated on the new regulations issued this past year which impose reasonable quality control standards. We have initiated an 18-month program which is designed to reduce error rates from the present national levels of 10 percent for ineligibility and 23 percent for overpayments to 3 percent and 5 percent, respectively. Our budget request for AFDC assumes that we will in fact achieve this quality control goal by the end of 1975. The State plans which we have received thus far evidence a genuine commitment to reach these levels. For the qualified AFDC recipients, this program has two benefits. In the process of reducing errors in overpayments, States are also reducing the number of errors in underpayments. In addition, the funds saved through error reduction may be used to increase benefits for the qualified recipient.

The budget for the old-age, survivors, and disability insurance trust funds includes an increase of $9 billion to a total of $64 billion in 1975. Most of this increase is the result of the implementation of the 11-percent benefit increase, with 7 percent effective in March and 4 percent effective in June.

HEALTH FINANCING

Our most significant initiative in health financing is not yet reflected in the HEW budget request. This is the legislation proposed by the President in February recommending enactment of the comprehensive health insurance plan. This program, which, if Congress acts this year, could be fully operational in fiscal year 1977, would insure that all Americans have access to health care at an affordable price with no increase in Federal taxes. My hope is that next year we will appear before this committee requesting funds to begin putting the new system into place.

The budget for medicare and medicaid in 1975 includes an increase of $2.7 billion. In medicare, besides increases in the size of the aged population and in the cost of health care services, coverage has been extended to nearly 2 million persons either entitled to disability benefits for at least 24 consecutive months or suffering from chronic kidney disease. The increase in medicaid outlays is primarily the result of extending coverage to all newly eligible SSI recipients.

Both the medicare and medicaid estimates are within the Cost of Living Council's guidelines on health costs which seek to restrain hospital cost increases to 10.5 percent and physician services to 4 percent. If medical cost inflation were permitted to return to the rate of inflation that prevailed before the Cost of Living Council was established, the budget estimate for HEW's health financing programs could be $500 to $600 million higher. I think that has to be borne in mind, Mr. Chairman, when we reflect on the possible effects of not extending the Cost of Living Council's authority to control health care cost after April 30.

In order to insure that both the quality and cost of the health care provided under these programs are reasonable, the Social Security Amendments of 1972 authorized the establishment of professional standards review organizations. The 1975 budget includes $58 million to finance this activity. This program is moving ahead on schedule. A significant milestone was reached when we proposed final regulations designating 203 operational areas in which professional standards review organizations could be formed. We expect to have 120 PSRO's funded by the end of fiscal year 1975.

STUDENT AID

This budget proposes a $1.3 billion appropriation to fund the basic educational opportunity grant program in 1975. This program provides grants directly to students based on their financial need, leaving them free to pursue the postsecondary education of their choice. We expect to make awards to 1.6 million students for school year 1975–76 with the neediest student receiving the maximum authorized grant of $1,400. When coupled with college work-study, an improved and expanded guaranteed student loan program, State and institutional student aid programs, and other student employment, our request for basic grants will assure students that they will not be deprived of a postsecondary education because of financial barriers.

Aid to States and Localities

The aim of HEW's programs of financial assistance to States, localities, and certain nonprofit private organizations is to increase their ability to provide human services, especially for the disadvantaged. This category includes programs for elementary and secondary education, social services, and a variety of health activities. Approximately $9.3 billion of the 1975 budget is allocated for this purpose.

The principal objective in this area is to permit State and local organizations greater responsibility and flexibility to carry out broad national priorities. Our 1975 budget and legislative program seek to simplify and consolidate a number of categorical grant programs into broader packages of Federal assistance which, we believe, will result in more effective and responsive delivery of services.

EDUCATION GRANTS CONSOLIDATION

Our most significant reform in education is the proposal to consolidate a number of education programs into the following broad categories: aid to the disadvantaged, education for the handicapped, support services, innovation, vocational education, and adult education. We are also prepared to submit 1974 supplementals to advance-fund all of these programs, thereby giving school districts adequate leadtime to plan programs for the next school year. If this legislation is enacted expeditiously, we will request supplementals totaling $2,852 million, an increase of $179 million over the regular 1974 appropriations for the relevant programs during the current school year. We would then add $23 million more to this total in the regular 1975 budget as advance funding for school year 1975–76.

When the budget was submitted in January, it appeared that final congressional action on the elementary and secondary education portion of our consolidation proposals was imminent. I am sorry to report that 2 months later the situation does not look as favorable. The House, Education and Labor Committee has reported an elementary and secondary education bill which carries out many of our objectives. The Senate, however, is working on a bill which would clearly be unacceptable to the President. Nevertheless, I'm still hopeful that an accommodation can be reached between the House and Senate which results in a responsible and acceptable bill being passed in advance of June 30.

EMERGENCY SCHOOL ASSISTANCE

Since 1970, the emergency school aid program has assisted 1,260 school districts, serving more than 10 million children, to overcome the problems attendant upon desegregation. The legislation authorizing this program expires at the end of 1974. Given the progress that has been made over the last several years, we are recommending new legislation to focus assistance on the remaining areas of greatest need. This new authority would provide for project grants at about one-third the 1974 appropriation for emergency school aid.

IMPACT AID

Once again we are recommending that a substantial cut be made in impact aid for children whose parents work but do not live on Federal property—the so-called B students. The budget proposal would terminate this category of impact aid except in special hardship cases where the reduction would exceed 5 percent of the current school budget in any district eligible for assistance. We would continue the current policy of funding A category children whose parents live as well as work on Federal property.

Our arguments against the continued funding of B category children are by now well known because they have been before you for many years. The parents of these children pay local property taxes and should be placed on the same footing as other members of the community. In the last several years, there has been growing acceptance of the need to cut back this inequitable program. Thus, the 1974 appropriation funds category B children at 63 percent of the authorization, down 5 percent from 1973.

HEALTH PLANNING SYSTEMS

The comprehensive health insurance plan provides the framework for reforming the Department's health activities. An important element of this effort is the consolidation and restructuring of health planning activities, both at State and local levels. Because the relevant legislation expires at the end of fiscal year 1974, we are now working with the health legislative committees to develop a new authority which would combine the health planning activities now supported under the comprehensive health planning program, Hill-Burton hospital construction, and the regional medical programs. Our proposal would establish health systems agencies which would be responsible for a health care planning system including facilities, services, and manpower. The agencies would include representatives from all five sectors of the health care market—consumers, providers, third-party payers, health education institutions, and government. They would be expected to identify deficiencies and maldistributions of health resources and work with the sectors of the health care market to overcome these problems. In addition, financial support would be provided to assist State efforts in regulating health care price increases and capital expenditures.

I believe the chances are good that Congress will pass health planning legislation along these lines. There remains, however, the question of future funding for hospital construction and the health care projects now supported by the regional medical programs. We are proposing that these authorities not be renewed. We believe that a nationwide formula grant for medical facility construction is no longer necessary because an adequate supply of hospital beds now exists nationwide. In fact, a surplus exists in many communities. Moreover, health care financing systems such as medicare, medicaid and private health insurance recognize capital expenses in their reimbursement calculation, placing capital financing of medical failities on a more business-like basis.

The authority for health care projects supported by the regional medical programs, in our opinion, should not be extended. To the extent these projects have produced useful results, other programs now exist in the cancer and heart institutes which adequately address the principal problems that RMP's were originally designed to solve. In addition, the new emergency medical services authority preempts further RMP activity in emergency medical service demonstrations.

HEALTH SERVICES

The Department provides financial assistance for a number of health service activities at the local level. These include community mental health centers, maternal and child health projects, neighborhood health centers, and family planning projects. While honoring our commitments to existing projects, our general policy is to start no new projects before comprehensive health insurance is enacted. The services provided through these projects would be included in the proposed benefit package, insuring more equitable access to these services than is currently possible under categorical grants.

In the case of neighborhood health centers, maintaining the 1974 level can be accomplished with slightly reduced appropriations because of greater reimbursements from existing third-party programs, principally medicaid.

We are again proposing no new starts for community mental health centers. The budget, however, includes the 1975 continuation costs of the new centers established with 1973 and 1974 funds. I would note here that our proposed health insurance benefit package covers up to 30 visits per year to a community mental health center.

Funding for maternal and child health activities will be carried forward at the 1974 appropriation level but, as required by law, all program funds will be distributed through formula grants in 1975. In making this transition, we have used the flexibility in the authorizing legislation to minimize the losses which individual States might experience as a result of moving to an all formula grant method of funding.

SOCIAL SERVICES

The program of social services to the poor, authorized by titles IV-A and VI of the Social Security Act, remains controversial. As you know, the new regulations which we put into effect last November have again, through congressional action, been suspended until December 31, 1974. Further legislative proposals are being considered in Congress which would make fundamental changes in the character and funding of this program.

Because of the uncertainty surrounding this program, States may spend less on social service activities than would otherwise be the case. We are monitoring this situation closely and will keep the Congress informed as we receive data from the States. For 1975, we are requesting an appropriation of $2 billion based on the estimates we received from the States in November 1973.

WORK INCENTIVES

In concert with the Department of Labor, we have been restructuring the work incentives program to concentrate its efforts on job placement rather than higher cost institutional training. As a result, job placements can be increased to 200,000 in 1974, up 63,000 from 1973 and maintained at that level in 1975. We believe this can be accomplished with a 1975 request $60 million below the 1974 appropriation.

VOCATIONAL REHABILITATION

Consistent with our effort to place greater reliance on the States, we are proposing to shift vocational rehabilitation funding formerly provided through project grants to State formula grant programs. These projects were started for the purpose of increasing the proportion of public assistance recipients receiving rehabilitation services. This has been accomplished and we expect continued progress to be made under the direct State program. We are projecting that 394,000 people will be rehabilitated with the 1975 appropriation request of $670 million, of which 88,000 are expected to be public assistance recipients. In addition to this $670 million in State grant funds, $137 million will be available for the rehabilitation of disabled beneficiaries from disability insurance trust funds and the supplemental security income program.

PROGRAM FOR THE AGING

Service programs for the aging will continue at the 1974 appropriation level. Our request of $100 million for nutrition services will allow us to maintain a program level of 200,000 meals, despite increases in the cost of food. The 1974 program included one-time start up costs which do not need to be repeated in 1975. Consequently, more will be available in the 1975 appropriation for delivering services than was available in 1974. Work will continue on the development of a network of community planning agencies to address the problems of the aged. Nearly every major locality should have an operating program by the end of fiscal year 1975.

HEAD START

We also plan to maintain the current operating level for Head Start. The budget would continue to support services for 379,000 children in full-year, summer and experimental Head Start programs. A budget increase of $38 million to $430 million is needed, however, to permit projects to meet operational cost increases and to fund overhead costs formerly provided by the Office of Economic Opportunity.

ALLIED SERVICES

We have submitted a revised allied services bill to the Congress. This legislation is designed to help streamline what is now a largely uncoordinated grants system created to provide a vast array of social services to citizens in need. HEW alone has more than 300 categorical programs administered by scores of different State and local agencies. The Allied Services Act of 1974 would provide technical and financial assistance to States, enabling them to plan and deliver services to clients more effectively. This bill is a major part of the Department's efforts to coordinate human service programs.

RESEARCH, TRAINING, AND INNOVATION

In total, our 1975 budget designates approximately $4 billion for development activities—research, development of skilled manpower, funding of innovative reforms and seed-money for building new service capacity.

The purpose of these activities is to support research of major national significance, correct shortages and imbalances which might develop the supply of skilled manpower, and encourage the development of innovative methods of delivering services.

NATIONAL INSTITUTES OF HEALTH

The proposed budget for biomedical research is $1.8 billion in 1975. The major expansion of cancer research begun in 1971 with the Cancer Act will be continued in 1975. Our request for the Cancer Institute includes an increase of $73 million over 1974 to $600 million, nearly twice the 1972 appropriation. Research into heart and lung disease would be increased by $23 million in 1975. All other institutes would be maintained at the 1974 level of appropriations, permitting continued investigation into such diseases as arthritis, diabetes, and asthma. Other areas of emphasis include the sudden infant death syndrome and sickle cell disease.

NATIONAL INSTITUTE OF EDUCATION

We are proposing a $130 million funding level for the National Institute of Education. A major portion of the Institute's budget will be focused on such high priority areas as improving the teaching of reading, making schools more responsive to student and parental preferences, getting a greater return on educational investments, and preparing students for careers.

The National Institute of Education has been the object of congressional criticism during the first year and a half of its operation. It is understandable that people in Congress, and the public at large, are impatient for some solid results from education research. But I would urge the Congress to allow the Institute to move forward now that the National Council on Educational Research is in place and has established explicit priorities and policies for the Institute. If funding is restricted to continuation levels only, there is little—if any—likelihood that we can mount an effective research effort in the field of education.

HEALTH MANPOWER

Over the years the Federal Government's responsibility to insure that the country has an adequate supply of health manpower has been fulfilled by greatly expanding health manpower training opportunities. If this expansion continues, there is a distinct possibility that there will be an oversupply of medical personnel in the years ahead. Therefore, our health manpower legislative and budget proposals seek to maintain current training capacity, and focus greater attention on the problems of encouraging a better geographic distribution of medical personnel, increasing the proportion of new doctors trained in the delivery of primary care, making better utilization of paraprofessionals, and attracting more women and minorities to the health professions.

OTHER SKILLED MANPOWER TRAINING PROGRAMS

The approach to the Nation's need for health manpower which I have just described is indicative of our policy on skilled manpower training in general. With the expansion of basic opportunity grants, college work study, and guaranteed student loans, the need for categorical training programs should be much less. In addition, we have proposed to the Congress that the statutory loan ceiling for the guaranteed student loan program be raised from $10,000 to $25,000 and that the annual borrowing limitation and loan payback periods be adjusted in order to meet the additional costs of graduate and professional education.

We are recommending, therefore, that most categorical training be shifted from formal, degree-type, institutional training to short-term, in-service training of personnel already in the field who lack specific skills or who need to learn new skills in order to keep up with changing times. Degree-oriented training is proposed for continuation in only a limited number of areas, such as vocational rehabilitation workers and teachers of the handicapped, where the supply of manpower will not meet the Nation's needs.

In the area of biomedical research, rather than general, across-the-board training, we have instituted a new program of postdoctoral fellowships in priority biomedical research areas. We expect to support 2,000 reseachers in 1974 and 3,700 in 1975 under this program. Similarly, rather than degree-oriented training of social workers, we are requesting funds for in-service training in such high priority areas as child abuse, foster care, and runaway youth.

HEALTH MAINTENANCE ORGANIZATIONS

The Health Maintenance Organization Act of 1973 provides us with the authority to demonstrate the viability of one of the most innovative ideas in health care delivery. The HMO concept complements the comprehensive health insurance plan by encouraging alternative systems of insurance and services, providing the public a wider variety of health delivery systems to choose from. By the end of 1975, we expect to have 38 federally assisted HMO's operational: when they develop to their full capacity, they will serve about 1 million people We expect to fund 170 HMO's over the life of the program.

As you know, Mr. Chairman, the comprehensive health insurance plan provides employees the option of enrolling in an HMO rather than a health insurance plan if that is what they wish.

DRUG ABUSE AND ALCOHOLISM

During the last several years, the Department has helped bring into being a narcotic addiction treatment capacity of 95,000 for the country as a whole. In 1975 we propose to rely more heavily on formula grant programs to the States to keep this capacity in place. Now that the country has gotten through the worst of the heroin addiction crisis, it is no longer necessary to expand treatment capacity. The emphasis in the project grant program in 1975 will be on developing new treatment techniques which can be replicated at the State and local level.

In alcoholism, we have funded approximately 480 innovative projects over the last 3 years. These have been effective in dramatizing the need to take actions against this problem and testing new techniques for rehabilitating alcoholics. In 1975, we are requesting a reduction in appropriations for project grants because most of these projects will have been completed by the end of this fiscal year. Within the $32 million requested for 1975, however, $20 million will be available for starting new activities. In addition to testing promising treatment techniques, these funds will be used to encourage private industry to set up programs to identify and counsel workers with alcoholism problems and assist States to implement model alcoholism legislation developed by the National Conference of Commissioners on Uniform State Laws.

STRENGTHENING DEVELOPING INSTITUTIONS

An area of special Federal concern and commitment has been support to institutions which serve significant percentages of blacks, Spanish-speaking Americans, American Indians, and other minorities. In 1975, we are requesting $120 million—the full authorization—in order to allow a selected number of such institutions to improve their programs and become fully developed within the next 5 years.

Program Management

A continuing objective of the Department is to manage programs efficiently so that the taxpayer gets full value for each dollar. As I indicated at the beginning of this statement, we have done our best to insure that our programs carry out their responsibilities with a minimum of Federal staff. We are mounting a new and more intensive effort to review staffing from the ground up in all of our programs. It is not enough to concentrate on incremental changes. I plan to make these kinds of reviews a regular part of our management activities. This, of course, is the zero-base budgeting system.

In addition to this general effort, there are three management areas which I would particularly like to call to your attention.

First, I believe that we should recognize the accomplishment of the Social Security Administration in implementing the supplemental security income program. This is, I think, the largest civilian job ever undertaken by the Federal Government. It required the transfer of accounts for 3 million aged, blind, and disabled persons from State welfare rolls to the Federal system. This involved working with 1,100 State and local welfare offices and agencies. In addition to handling converted State cases, the Social Security Administration will be receiving over 2.5 million new claims in the remainder of fiscal year 1974 and is administering State-financed supplementary payments on behalf of 33 States.

I do not want to leave the impression that this task was accomplished without hardship. Inevitably, some people, particularly in some large metropolitan areas, did not receive checks or they got one in the wrong amount. This was largely due to incorrect addresses furnished to us by the State and local governments. This occurred in a small percentage of cases, about 6 percent. We are working to reduce this percentage still further.

Rapid growth in the guaranteed student loan program has caused management problems which we are moving to correct with resources requested in this budget. Default claims have risen dramatically in recent years, both in absolute numbers and as a proportion of loans in repayment status. We must take prompt action to bring this situation under control.

To this end, we have requested 322 positions to improve collections, do a better job of monitoring schools and lenders, and upgrade management information systems and program procedures. Besides requesting new staff, we are working on tighter regulations and legislative amendments to prevent defaults from occurring in the first place.

I would also like to underscore the need for an increase of 135 positions for overall departmental management, including the regional offices. This staff is essential to carrying out the Department's legislative responsibilities and its obligations to the public which it serves. Particularly important, in my view, is the need to provide adequate staff for the General Counsel to handle a workload that has grown significantly because of legislation which has been enacted in the last several years. The SSI program alone could result in 1,000 court cases stemming from administrative hearings. There has also been a 39-percent increase in court cases because of more vigorous food and drug enforcement activity. We are also asking Congress to reconsider the decision to drastically reduce the investigations unit in the Office of Administration. We believe that this unit performs a very useful function in protecting the integrity of our programs. But it cannot do an effective job with its current very limited staff.

To give you an idea, Mr. Chairman, of the magnitude of this particular activity we have awarded 43,600 grants and 23,000 contracts totaling over $7.5 billion. We believe that we should be able to assure you and the other Members of Congress, and the people that the recipients of these grants are managing them free from conflict of interest or actual dishonesty. That is the reason we have requested an increase in the Investigations Unit.

This concludes my prepared statement. I will be happy to try to answer any questions you may have.

Mr. FLOOD. Mr. Secretary, when you appeared before this committee last year you had been on the job about 2 weeks.

Secretary WEINBERGER. Right.

Mr. FLOOD. You still had one foot over in the Office of Management and Budget and you were known throughout this city, even as far away as Baltimore, as Cap the Knife. I think by this time you have more or less sort of pleasantly embraced the title.

As you know, the members of this committee have seen quite a few Secretaries of HEW come and go like the hours of day and night. We usually found this Office has an effect upon them more or less. Do you find that you look upon things a little differently after a year down there at HEW? Have you changed your mind about anything during the last year?

Secretary WEINBERGER. I hope I have grown and developed and learned a greal deal, Mr. Chairman, in the course of the year. I would be pretty disappointed in myself if I had spent 12 such interesting and exciting months without learning and growing in many areas.

Mr. FLOOD. That is what is known as a leading question.

Secretary WEINBERGER. Yes, it is. I didn't object to it however.

TERMINATION OF PROGRAMS

Mr. FLOOD. Last year you had quite a list of programs that you proposed to terminate.

Secretary WEINBERGER. Yes.

Mr. FLOOD. Would it be correct to say you are proposing essentially the same list of terminations and phaseouts you proposed last year?

Secretary WEINBERGER. No. There are a few which we are continuing to recommend for that fate, but we have not recommended the same entire list, and we have accepted the decisions of the Congress in many areas where we felt last year that the funds could be better used elsewhere. For example, the Public Health Service hospitals. We asked for funding for those although we believe that the Federal Government should no longer provide direct delivery of health services. None the less, we have accepted the congressional decision on that.

Mr. FLOOD. Suppose you prepare for the record a list of the programs proposed for termination and phaseout in the 1974 budget and of course, a similar list for the 1975 budget together with the amounts involved.

Secretary WEINBERGER. We have that information and could put it in the record.

[The information follows:]

PROGRAMS PROPOSED FOR TERMINATION IN FISCAL YEAR 1974 AND 1975

[In millions of dollars]

	1974 budget request	1974 appropriation	1975 budget request
Health Services Administration: Maternal and child health project grants	0	111	0
National Institutes of Health:			
Research resources: General research support	17	44	0
Alcohol, Drug Abuse, and Mental Health Administration:			
General mental health:			
Construction of centers	0	14	0
Staffing of new centers	0	31	0
Health Resources Administration:			
Health resources:			
Comprehensive health planning	38	42	0
Regional medical program	0	75	0
Health professions: VOPP capitation	0	33	17
Nursing:			
Capitation grants	0	34	0
Financial distress grants	0	5	0
Traineeships	0	13	0
Special projects	0	7	0
Public health	0	21	0
Allied health	0	35	0
Health facilities construction	0	197	0
Health teaching facilities	0	114	0
Assistant Secretary for Health: Scientific activities overseas	2	2	0
Office of Education:			
Elementary and secondary education:			
Strengthening State department of education	0	39	[1] 39
Equipment and minor remodeling	0	29	[1] 29
Drug education	3	6	0
Nutrition and health	0	2	[1] 2
Environmental education	0	2	[1] 2
School assistance in federally affected areas: "B" category children	0	307	[2] 40
Emergency school aid:			
Special projects:			
Bilingual education projects	10	10	0
Educational television	7	7	0
Special programs and projects	12	12	0
State apportionment:			
Pilot programs	37	37	0
Special programs and projects	20	20	0
General grants to LEA's	147	147	0
Occupational, vocational, and adult education:			
Education professions development:			
Vocational education	0	11	0
New careers in education	0	0	0
Higher education	2	2	0
Ethnic heritage studies	0	2	0
Higher education:			
Student assistance:			
Supplementary opportunity grants	0	210	0
NDEA direct loans	0	288	0
Incentive grants for State scholarships	0	19	0
Institutional assistance:			
University community services	0	14	0
Aid to land-grant colleges	0	10	0
State postsecondary education commissions	3	3	0
Veterans cost of instruction	0	24	0
Library resources:			
School library resources	0	90	[1] 90
College library resources	0	10	0
Undergraduate instructional equipment	0	12	0
Training and demonstrations	0	4	0
Social and Rehabilitation Service:			
Public assistance training projects	0	8	0
Rehabilitation services: Vocational rehabilitation, innovation, and expansion	30	29	[3] 29
Human development: Aging training	0	10	0

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[1] To be included in the education grants consolidation.

[2] Dollars represent on-time payments to prevent undue hardhsip as a result of program termination.

[3] Included in basic State grants in fiscal year 1975.

NEW OR EXPANDED PROGRAMS

Mr. FLOOD. Then also give us a list of any new or expanded programs proposed for the 1975 budget.

Secretary WEINBERGER. We have that information and will be glad to furnish it.

[The information follows:]

NEW OR EXPANDED PROGRAMS PROPOSED FOR THE FISCAL YEAR 1975 BUDGET

Health

Proposed consolidation of the diverse and often uncoordinated health planning activities into a new health resources planning proposal with a $75 million funding level.

A new health manpower legislative proposal stressing geographic distribution and equal access to health professions for women and minorities—$369 million proposed in budget.

Funding of recently enacted health maintenance organization legislation—$30 million in 1974 and $45 million in 1975 for grants and contracts and $50 million to capitalize a direct loan fund.

Expansion of biomedical research in cancer (up $73 million) and heart disease (up $23 million).

Creation of a national network of professional standards review organizations to assure effective utilization of federally financed health services—$58 million included in 1975 budget.

Education

Consolidation of education grant programs with a supplemental proposed for 1974 to advance fund the 1974-75 school year (up $179 million over the $2.7 billion appropriated in 1974 for the individual programs and an additional $23 million in the 1975 budget for the 1975–76 school year).

Full funding of the basic opportunity grants program to provide student financial assistance for the disadvantaged and lower income families—$1.3 billion included in budget, an $825 million increase.

Increased funding for the National Institute of Education—a $25 million proposed supplemental (over the $75 million appropriated) for 1974 and an additional $30 million in 1975.

Increased funding for black colleges and other developing institutions—up $20 million in 1975.

A new legislative proposal to focus Federal assistance for public libraries on developing information networks to make more efficient use of all kinds of library materials—1975 proposed funding level: $15 million.

Three-hundred and thirty new positions to improve the management of the guaranteed student loan program, improve collections on defaulted loans and reduce the incidence of defaults.

Other

Allied services legislation to provide more flexibility to State and local governments for developing and delivering human services—$20 million included in the 1975 budget.

Mr. FLOOD. When you began your statement you stated that if the proposals you made last year had been adopted by Congress there would have been a saving of what, $2 billion and about 7,000 jobs?

Secretary WEINBERGER. The same list that you requested first with requested, and of course same programs adopted by the Congress earlier, such as the SSI program, did require increases. But we think there would have been a net savings of roughly $2 billion and several thousand employees.

ESTIMATED SAVINGS FROM TERMINATED PROGRAMS

Mr. FLOOD. What we would like to have is a breakdown set up for the record on that and tell us how you arrived at the savings.

Secretary WEINBERGER. The same list that you requested first with respect to terminated programs would show roughly $2 billion.

[The information follows:]

Fiscal year 1974 increase in employment as a result of congressional action or inaction

	Increases
Public health service hospitals	+2,455
National health service corps	+115
Maternal and child health	+53
Center for Disease Control	+211
National Institute of Health	+112
St. Elizabeths	+3,991
Health Resources Administration	+387
Office of Education	+250
Total	+7,574

EFFECT OF CONGRESSIONAL ACTION ON PROPOSED 1974 BUDGET REDUCTION

[In millions of dollars]

	1974 budget request	1974 appropriation after $400,000,000 reduction
Health:		
Mental health:		
Community mental health center construction	0	14
Staffing of new centers	0	31
Mental health of children	8	19
Alcoholism:		
Training	4	7
Project grants	40	67
Regional medical program	0	75
Hill-Burton hospital construction	0	197
Biomedical research:		
General research support	17	45
Training grants and fellowships (includes NIH and NIMH)	198	259
Health manpower:		
Health professions:		
VOPP capitation	0	33
Scholarships	10	15
Construction	0	95
Nursing:		
Capitation	0	34
Financial distress	0	5
Scholarships	11	19
Traineeships	0	13
Construction	0	19
Public health	0	21
Allied health	0	35
Education:		
ESEA:		
Strengthening State departments of education	0	39
Equipment and minor remodeling	0	29
Follow Through	41	41
Impacted aid "B" category	0	307
Higher education:		
NDEA direct loans	0	[1] 288
Supplemental opportunity grants	0	[1] 210
Language training	1	13
Aid to land-grant colleges	0	10
Veterans cost-of-instruction	0	24
University community services	0	14
College personnel development	6	6
Education professions development (other than Teacher Corps)	36	60
Drug abuse education	0	6
Environmental education	0	2
Nutrition and health	0	2
Dropout prevention	4	4
Ethnic heritage studies	0	2
Library programs:	0	
Public library services	0	47
Library construction	0	0
School libraries	0	90
College libraries	0	10
Undergraduate equipment	0	12

EFFECT OF CONGRESSIONAL ACTION ON PROPOSED 1974 BUDGET REDUCTION—Continued

[In millions of dollars]

	1974 budget request	1974 appropriation after $400,000,000 reduction
Social and Rehabilitation Service:		
Vocational rehabilitation training	17	16
Aging training	0	10
Community services training	0	8
Vocational rehabilitation facilities	0	0
Related agencies:		
Office of Economic Opportunity	144	329
Total	534	2,572
Difference (amount that could have been saved)	2,038	

[1] Increase offset by corresponding reduction in basic opportunity grant (BOG's).

WILLINGNESS TO COMPROMISE

Mr. Flood. Last year, you remember I told you I was quite certain that Congress would reach judgments about the allocation of the resources different from those that appeared in the budget. Of course, that prediction turned out to be accurate.

Secretary Weinberger. Yes, it did, sir.

Mr. Flood. Now, I have a suspicion that the same thing might happen again this year, all things being equal under the circumstances and so on. If it does, are you willing to compromise?

Secretary Weinberger. We, I think, have displayed a commendable flexibility in many areas, Mr. Chairman. For example, the Under Secretary has been working very closely with the congressional committees on our education grants consolidation proposal, and we have made several significant agreements on portions of that in an attempt to reach an acceptable result prior to June 30. We have in the proposals before you, we believe, very firm and logically compelling reasons for the recommendations we have made.

We recognize that the function of the President is to give the Congress the benefit of his best judgment in making his recommendations, and the function of the Congress historically has been to appropriate the funds. Over the years, executives have learned to work with the amounts that they have been authorized.

Mr. Flood. Your answer is yes?

Secretary Weinberger. Just about. Compromise has a difficult meaning which I wanted to explain to you in that historical background.

Mr. Flood. You did.

THE 1975 BUDGET

As we look at your 1975 budget, we find it proposed an increase in budget authority for the so-called noncontrollable programs, and a decrease in budget authority for so-called controllable programs. Is that right?

Secretary Weinberger. I don't think there is a decrease. One of the problems is, Mr. Chairman, that the 1974 budget reflects the supplemental which we hope to send up for the forward funding for education, which would have an effect of swelling the 1974 budget with a 1-year bulge, and that would appear to indicate some reductions in 1975. Generally speaking, in the controllables, outlays would go up a small amount. In the Federal funds, budget authority would go down. But I think this is explained by the 1-year bulge that is in the 1974 budget *to take care of both the forward funding* and the release of funds that were previously not earmarked for spending in 1974.

Mr. FLOOD. It would go down?

Secretary WEINBERGER. Yes, it would go down because 1974 is an unnatural sort of 1-year bulge.

NONCONTROLLABLE PORTION OF BUDGET

Mr. FLOOD. What percent of your Federal funds would be what we call a noncontrollable, excluding trust funds?

Secretary WEINBERGER. I don't have the breakdown. Of the total HEW budget 94 percent is uncontrollable.

Mr. FLOOD. What arguments can we use for cutting back funds for so-called controllable programs when we know inflation is going to increase the costs of these programs?

Secretary WEINBERGER. I think, Mr. Chairman, again I have to go back to the point I mentioned a moment ago. When you say cutting back you are speaking of reducing from the 1974 totals, and in many cases, if you just look at overall totals, there would be a reduction because 1974 has a 1-year bulge in it that is not found normally. There is $2.8 billion in 1974 for forward funding for the schools.

ADDITIONAL 1975 FUNDS

Mr. FLOOD. Are there programs for which you would request additional funds if the fiscal situation would permit it?

Secretary WEINBERGER. We believe that this budget for fiscal 1975 reflects the priorities and the allocations that we believe should be made, having in mind overall governmental problems and resources.

Mr. FLOOD. Would you characterize your 1975 budget request as a tight one? Can we cut anywhere?

Secretary WEINBERGER. The principal way in which reductions could be made in the request that we have submitted, Mr. Chairman, would be in the revision of the programs themselves that force certain categories of expenditure into the uncontrollable category; 94 percent are uncontrollable. To get reductions in those areas it would be necessary to repeal or terminate certain existing programs, and there was marked reluctance to follow that route when it was proposed last year. It would be possible to reduce certain benefits in certain programs, but that has also been considered unthinkable.

I would say that the budget we have submitted reflects the President's feeling as to the proper allocation of a very substantial amount of resources, over a third of the entire Federal budget, and that while reductions could be made in it beyond those that we have proposed, it would be necessary to terminate programs. The attitude of the Congress toward that possibility last year did not seem promising.

HEW EMPLOYEE MORALE

Mr. Flood. We have a lot of reports that the morale among the HEW employees was very, very low. Are these reports accurate in your judgment? If so, what can be done about it?

Secretary Weinberger. No, sir, they are not accurate in my judgment.

The principal newspaper accounts that keep repeating this—and they are somewhat similar to the ability that the country has to talk itself into a recession by constantly saying things are terrible—refer primarily to the National Institutes of Health. Our examination of the problems there lead me to believe that the only way in which these newspaper articles could be changed—I am not saying they correctly reflect the morale situation—would be if there were major increases in every single budget item that is associated with the National Institutes of Health.

We have submitted certain priorities to the Congress in the President's budget. Those priorities involve increases in cancer and heart research. They also involve holding other areas of the National Institutes of Health biomedical research relatively steady for a total expenditure of $1.8 billion. I suppose you could buy newspaper articles that were free of the charge that morale is bad if you added another $2 or $3 billion. However, I don't think that you would get programmatic advantages that would justify such increases, and I don't think the newspaper articles are very accurate about morale. I think you find that an occasional individual who has a job offer that is more attractive somewhere else will retire or resign saying he doesn't like conditions. This will be picked up as reflecting an entire feeling throughout the agency.

I will say just one thing that leads me to believe that morale is good. Certainly throughout the Department I have not encountered any problem that indicates it is not good and the only newspaper accounts of poor morale concern NIH. But at NIH I might say employees for the first time exceeded their quota in the combined Federal campaign: in fact, the Department as a whole exceeded its quota. I would think this is a reasonably important index of the fact that morale is pretty good in some of those areas.

REGIONALIZATION

Mr. Flood. I will ask the question and there will be four or five items under it and you give us a good statement for the record in response to all of these questions.

Indicate why you think this matter of regionalization is such a good idea. We are getting a lot of complaints about the policy of decentralizing programs to regions. We would like to know several things.

First how many jobs have you actually transferred to the regions? How many more do you plan to transfer? Why is there so much opposition to regionalization and some examples of where you have been successful in the regional operation.

This whole thing of decentralization. Tell us about it now and for the record give us a statement.

[The following information was submitted:]

In HEW we make an important distinction between decentralization and regionalization. By "decentralization," we mean a delegation of program authority from a program official in Washington, such as the Commissioner of Education, to his counterpart in a region, such as a Regional Commissioner of Education. Except in the Office of Human Development, that delegation does not go through the HEW Regional Director.

When we use the term "regionalization," we are talking about the functions that are the responsibility of the HEW Regional Director. They may be both program functions and management functions such as planning, evaluation, or financial systems.

We believe firmly that both decentralization and regionalization will enhance our capabilities to serve more effectively the HEW constituencies. However, the activity that we are principally engaged in, and the one to which your questions appear to be pointed, is decentralization.

We start out our decentralization effort by taking a look at the overall goals of HEW. As one of the major goals of the Department of Health, Education, and Welfare, we try to reduce the dependency of the citizens that we serve. For example, we seek to move them up a ladder that may go from institutionalization to self-sufficiency and self-support. And, experience has indicated to us that, to reduce this dependency, a wide range of services might well be required. Take a look at the problems that face a pregnant, high school dropout who may have a drug problem and think of the range of services that this person would require.

But, unfortunately, the way our programs are structured, the odds are often very much against that person receiving the full range of services. We have created, for example, a variety of single-State agencies—single-purpose local agencies. We have created, in effect, vertical hierarchies when horizontal partnerships may be more in order to provide that full range of services. Accordingly, we believe in the concept of a Department of HEW and, indedd, believe firmly in the concept of a human resources department, in which education, health, and income maintenance are related.

We are concerned when education is considered in isolation, without recognizing that the education of a child may well depend on the health of that child, upon his nutrition—and going further, on the home environment. Educators tell us that the home environment is more important to education than we had thought it was. Or, to look at the equation from the other side; the doctors tell us that the future in health is in the area of preventive medicine and in health education. But, should we try to talk about health education without talking about our education system in general and what role that can play in health education.

So we think that these kinds of relationships have to be developed and fully exploited. We think that a lot of them can be developed at the State and local level. We think that the closer the DHEW people are to the actual problems, the better they can develop these relationships.

In our present system, we have quite a mix of programs. We have formula programs which run through States; we have project grants which are totally discretionary in some of the HEW agencies; we have different eligibility requirements; we have different audit requirements; we have different financial requrements; we have different local matching requirements.

The trick is to try to identify obstacles and try to bring interrelated programs together. For example, the Governor of Florida has spent a year in just identifying the Federal obstacles to services integration. He is now prepared to move forward, but he had to spend a very long time just figuring out what those obstacles are.

In looking at how to overcome the obstacles, we are trying to determine at what point in the HEW structure we can best provide our range of services. However, we obviously have functions such as legislation development, the preparation of the budget, and policy formulation, which can only be handled in Washington.

We are not talking about decentralizing these functions. What we are basically talking about is policy and program implementation. Even then, in some instances, it may not be desirable to decentralize that function. National R. & D programs conducted by the National Institute of Education are fairly obvious examples. And, there are other programs where some functions might well be decentralized while others remain in Washington.

Each program is examined separately. Essentially, our criteria are legislative guidance with the prescriptions of statutes, program effectiveness, and our ability to develop horizontal relationships.

Our regional offices have the freedom and capability to be oriented toward total community problems. Indeed, their effectiveness is evaluated on how responsive they are to community problems. On the other hand, effectiveness of Washington organizations may be related to many different things.

In regard to the movement of positions, there is a misconception that somehow we are engaged in a wholesale shifting of HEW employees from Washington to the regional offices. To the contrary, we have spent a considerable amount of time in a very careful planning process—in dialog between the Office of the Secretary and the various agencies. At a maximum, we would only be talking about transferring 1,400 positions to the regions. And, based on prior experience, that may come down to some 700 employees, probably a lot less, that actually would be moving out of the total HEW complement of 126,000 employees.

There is another misconception that, somehow, we are adding an extra layer in decentralizing. To the contrary, the purpose of decentralization is to remove a layer. Right now in most programs, the initial point of contact is at the regional office. They assist with the processing; but with a program, the final decision has to be made in Washington. We are talking about putting authority, final authority, for whatever function it may be—whether audit, technical assistance, or approval for a grant—in the regional office so that those we serve can get quick, final response from that regional office. And, we are also talking about giving the regional office the resources to carry out that authority.

Another objection that follows along with the extralayer misconception is that we will not have consistent policy among regional offices if we decentralize. Of the concerns that have been raised, we think this is perhaps that most serious. It is an issue that we do have to address. We have to solve it by improving our communications with our regional offices; by making sure that our regional officials understand policy, by more frequent conferences, by training programs, and by evaluating our regional offices.

All of these we are doing and we think experience has indicated that where you make a major effort to keep regional officials informed of policy, you can have policy consistency among regions. A striking example of a program that is successfully operated in a decentralized mode is the social security system.

The answer to decentralization centers around determining the interface between the grantee and the actual recipient of the program. As we look at those programs that we think can be better administered in the field, we find that they center around those programs in which we fund grantees who will actually provide services at the local or community level. It is this type of program which needs to be coordinated with other programs within HEW, with other programs within the Federal Government, and with other State and local programs at the regional level. In this way, duplication can be avoided and, more importantly, the quality and availability of service can be increased.

On the other hand, there are programs that are obviously more effectively administered in Washington, such as those that require national competitions. The best examples of this, of course, are our biomedical research programs that deal with an entirely different kind of grantee community.

As we look at each program, we examine the objectives of the program to determine if it needs to be pulled together at the regional level. We think that those programs which need coordination at the regional level can be better administered in the field. In summary, we believe that decentralization, properly administered—and, we are moving very carefully—can enhance the Department's capability to carry out congressional intent.

Secretary WEINBERGER. I would be glad to.

Let me at the beginning clear up a terminological problem. Regionalization to some people means we are trying to encourage cities and countries to consolidate and create bigger local regions and deal with them, and that is not what we are doing. I think the term "decentralization" is much more accurate and gets us away from what some people feel is a wrong policy but which is clearly a policy we are not following.

We are engaged in carrying out a policy of decentralization. We believe strongly in it. Basically the idea is that if we can give additional grant-making authority, discretionary authority, to the people at the regional office level, if we can decentralize some of that authority to these people, we believe they will be better able to deal with Governors and with mayors and with citizens instead of having these officials go through the long waiting process that is required to relay applications and requests for decisions and so on to Washington where the decision will be made by people who are not as familiar with local conditions as the people in the regional offices are.

That is basically the reason for decentralization. It is part of the President's new federalism concept that is expressed best, I think, by saying that he wants to distribute both funds and decisionmaking authority out of Washington to the Federal regional offices so that the existing State and local government agencies and individuals can get answers to their questions a lot more rapidly and a lot more effectively made by people on the spot who know local conditions better than we do in Washington. That is the basic idea we have in mind, the goal we hope to achieve with decentralization.

As far as the progress of the program is concerned, we have started it, we have begun training, we have begun the announcement and dissemination of the programs that we want to decentralize the regions, and we have started, although on a very small scale, transferring some personnel on a voluntary basis who wish to go to the regions to help carry out these activities.

The precise figures involved in decentralization I could enter in the record later, but we have begun, and we have begun thus far on a comparatively small scale because it is a big job and we want to do it properly.

HEW ADVISORY COUNCILS

Mr. FLOOD. HEW is harboring a lot of advisory councils, committees, which for one reason or other have been established by law. Suppose you give us a list for the record of the statutory advisory councils and committees showing the number of employees each one has, the amounts budgeted for each one in fiscal years 1974 and 1975.

Secretary WEINBERGER. I will be glad to do that, Mr. Chairman.

I also think I should say that we are making a substantial effort to reduce the number of advisory councils, commissions, and committees because we had over 400 when I first came, and we think that this does represent much too large and unwieldy a number to try to deal with or for the Government to get any real benefit from. So we are making a conscious effort to reduce them.

Obviously where statutes are involved we would ask repeals. But where the councils and committees are established by Executive order or by departmental order we are making, and have made, a substantial reduction in the numbers, in staffing, and in staffing costs.

[The following information was submitted:]

HEW ADVISORY COMMITTEES

CALENDAR YEARS 1973–74

Complying with the Federal Advisory Committee Act (Public Law 92-463), the Office of Management and Budget (OMB) requires from each Department and agency which uses them:

An annual report on the number of advisory committees the previous calendar year; and

An annual review to reduce, as much as feasible, the number of advisory committees in existence.

Therefore data on committee is now recorded, compiled, and analyzed on a calendar year basis, to be consistent with the requirements of this law and the instructions of OMB implementing it.

The HEW annual report to OMB for calendar year 1972 showed 368 advisory committees in existence as of December 31, 1972. An estimated 64 additional committees existed at that time in the National Cancer Institute, which is housed in HEW, for a total of 432 committees at the start of calendar year 1973.

The estimated aggregate annual cost of all advisory committees existing in HEW at the beginning of calendar year 1974, including the cost of the 314.57 estimated man-years of staff support to be provided to them, is $12,414,050.

A list is attached, showing the name, estimated man-years of staff support, and estimated cost of each of the 286 advisory committees in HEW at the beginning of calendar year 1974. All of these committees were established and are managed in accordance with Public Law 92–463.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

LIST OF ALL ADVISORY COMMITTEES AT THE BEGINNING OF CALENDAR YEAR 1974

	Estimated Man-Years of staff support	Estimated cost
1. Adult Development and Aging Research Committee (NIH)	1.00	$27,000
2. Advisory Committee on Accreditation and Institutional Eligibility (OE)	1.00	35,000
3. Advisory Committee to the Director, NIH (NIH)	.75	23,000
4. Advisory Committee on the Education of Bilingual Children (OE)	0	0
5. Advisory Committee on Medicare Administration Contracting and Subcontracting (SSA)	2.25	55,220
6. Advisory Council on Developing Institutions (OE)	.20	11,000
7. Advisory Council on Financial Aid to Students (OE)	0	0
8. 1974 Advisory Council on Social Security (SSA)	0	0
9. Alcohol Training Review Committee (ADAMHA)	1.10	50,552
10. Alcoholism and Alcohol-Problems Review Committee (ADAMHA)	1.05	61,875
11. Allergy and Immunology Research Committee (NIH)	1.50	50,000
12. Allergy and Immunology Study Section (NIH)	2.50	89,843
13. Animal Resources Advisory Committee (NIH)	1.50	33,644
13. Animal Resources Advisory Committee (NIH)	1.50	33,644
14. Anti-Infective Agents Advisory Committee (FDA)	.30	13,000
15. Applied Physiology and Bioengineering Study Section (NIH)	1.70	48,368
16. Arteriosclerosis Research Centers Advisory Committee (NIH)	.15	14,625
17. Artificial Kidney-Chronic Uremia Advisory Committee (NIH)	.50	29,000
18. Automation in the Medical Laboratory Sciences Review Committee (NIH)	.75	61,500
19. Bacteriology and Mycology Study Section (NIH)	3.00	99,780
20. Behavioral Sciences Research Contract Review Committee (NIH)	.30	12,000
21. Biochemistry Study Section (NIH)	3.00	89,020
22. Biomedical Communications Study Section (NIH)	.50	38,367
23. Biomedical Library Review Committee (NIH)	.75	37,275
24. Biometric and Epidemiological Methodology Advisory Committee (FDA)	.20	11,000
25. Biometry and Epidemiology Contract Review Committee (NIH)	.15	22,500
26. Biophysics and Biophysical Chemistry A Study Section (NIH)	2.00	66,590
27. Biophysics and Biophysical Chemistry B Study Section (NIH)	2.00	66,057
28. Bladder-Prostate Cancer Advisory Committee (NIH)	.60	31,000
29. Board of Advisors to the Fund for the Improvement of Postsecondary Education (OS)	.23	23,800
30. Board of Regents of National Library of Medicine (NIH)	.75	21,000
31. Board of Scientific Counselors, NCI (NIH)	.10	5,000
32. Board of Scientific Counselors, NEI (NIH)	.08	4,600
33. Board of Scientific Counselors, NHLI (NIH)	.14	8,000
34. Board of Scientific Counselors, NIAID (NIH)	.05	5,250
35. Board of Scientific Counselors, NIAMDD (NIH)		6,700
36. Board of Scientific Counselors, NICHD (NIH)	.15	5,500
37. Board of Scientific Counselors, NIDR (NIH)	.13	10,000
38. Board of Scientific Counselors, NIEHS (NIH)	.50	12,800
39. Board of Scientific Counselors, NIMH (ADAMHA)	.25	8,242
40. Board of Scientific Counselors, NINDS (NIH)	.50	17,435
41. Board of Tea Experts (FDA)[1]	.10	2,000
42. Breast Cancer Diagnosis Committee (NIH)	.50	30,000
43. Breast Cancer Epidemiology Committee (NIH)	.50	20,000
44. Breast Cancer Experimental Biology Committee (NIH)	.50	25,000
45. Breast Cancer Treatment Committee (NIH)	.50	25,000
46. Cancer Clinical Investigation Review Committee (NIH)	4.25	65,907
47. Cancer Control Advisory Committee (NIH)	1.50	35,611
48. Cancer Control Education Review Committee (NIH)	0	0
49. Cancer Control Prevention and Detection Review Committee (NIH)	0	0
50. Cancer Control Treatment and Rehabilitation Review Committee (NIH)	0	0
51. Cancer Research Center Review Committee (NIH)	1.60	72,125
52. Cancer Special Program Advisory Committee (NIH)	.20	10,000
53. Cancer Treatment Advisory Committee (NIH)	.07	6,000
54. Cardiovascular and Pulmonary Study Section (NIH)	2.00	81,908

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE—Continued

LIST OF ALL ADVISORY COMMITTEES AT THE BEGINNING OF CALENDAR YEAR 1974—Continued

	Estimated Man-Years of staff support	Estimated cost
55. Cardiovascular and Renal Advisory Committee (FDA)	.30	13,000
56. Cardiovascular and Renal Study Section (NIH)	2.00	79,631
57. Cell Biology Study Section (NIH)	3.00	89,173
58. Chemical/Biological Information-Handling Review Committee (NIH)	.20	4,633
59. Clinical Program-Projects Research Review Committee (ADAMHA)	1.50	49,454
60. Clinical Projects Research Review Committee (ADAMHA)	2.50	88,035
61. Clinical Psychopharmacology Research Review Committee (ADAMHA)	1.33	63,696
62. Coal Mine Health Research Advisory Council (CDC)[1]	.47	19,000
63. Colon-Rectum Cancer Advisory Committee (NIH)	.33	11,800
64. Committee on Cancer Immunobiology (NIH)	.50	25,000
65. Committee on Cancer Immunodiagnosis (NIH)	.50	25,000
66. Committee on Cancer Immunotheraph (NIH)	.50	25,000
67. Committee on Cytology Automation (NIH)	.20	10,000
68. Committee on the Immunology of Cancer Cause and Prevention (NIH)	0	0
69. Communicative Disorders Review Committee (NIH)	2.00	75,000
70. Communicative Sciences Study Section (NIH)	2.00	81,995
71. Computer and Biomathematical Sciences Study Section (NIH)	3.00	142,192
72. Consumer Advisory Council (OS)	.40	25,000
73. Continuing Education Training Review Committee (ADAMHA)	.44	28,000
74. Contraceptive Development Contract Review Committee (NIH)	.15	5,000
75. Contraceptive Evaluation Research Contract Review Committee (NIH)	.30	9,000
76. Controlled Substances Advisory Committee (FDA)	0	0
77. Crime and Delinquency Review Committee (ADAMHA)	.80	32,000
78. Dental Caries Program Advisory Committee (NIH)	.10	9,900
79. Dental Drug Products Advisory Committee (FDA)	.30	13,000
80. Dental Research Institutes and Special Programs Advisory Committee (NIH)	0	0
81. Dental Study Section (NIH)	2.00	119,944
82. Dermatology Advisory Committee (FDA)	.30	13,000
83. Developmental Behavior Sciences Study Section (NIH)	2.00	89,982
84. Diagnostic Products Advisory Committee (FDA)	.30	14,000
85. Diagnostic Radiology Committee (NIH)	.30	15,000
86. Diagnostic Research Advisory Group (NIH)	.50	140,000
87. Drug Experience Advisory Committee (FDA)	.30	15,000
88. Emergency Medical Services Administrator's Advisory Committee (HSA)	.35	12,000
89. Endocrinology and Metabolism Advisory Committee (FDA)	.30	13,000
90. Endocrinology Study Section (NIH)	3.00	94,204
91. Epidemiologic Studies Reveiw Committee (ADAMHA)	1.17	44,000
92. Epidemiology and Biometry Advisory Committee (NIH)	.80	10,200
93. Epidemiology and Disease Control Study Section (NIH)	2.00	92,147
94. Epilepsy Advisory Committee (NIH)	.75	28,050
95. Experimental Psychology Research Review Committee (ADAMHA)	2.00	68,539
96. Experimental Psychology Study Section (NIH)	2.00	87,672
97. Experimental and Special Training Review Committee (ADAMHA)	.35	22,000
98. Experimental Therapuetics Study Section (NIH)	2.50	82,300
99. FDA-NIMH Drug Abuse Advisory Committee (FDA)	.30	15,000
100. Federal Council on the Aging (OS)[1]	1.33	29,379
101. Federal Hospital Council (HRA)[1]	.60	26,834
102. General Clinical Research Centers Committee (NIH)	.50	30,508
103. General Medicine A Study Section (NIH)	2.00	104,756
104. General Medicine B Study Section (NIH)	2.00	83,221
105. General Research Support Program Advisory Committee (NIH)	1.50	27,912
106. Genetics Study Section (NIH)	3.00	147,063
107. Health Care Technology Study Section (HRA)	1.75	118,075
108. Health Insurance Benefits Advisory Council (SSA)[1]	10.00	200,000
109. Health Services Developmental Grants Sutdy Section (HRA)	2.50	161,881
110. Health Services Research Study Section (HRA)	2.00	117,810
111. Health Services Research Training Committee (HRA)	.50	13,838
112. Heart and Lung Program-Project Committee (NIH)	5.00	235,000
113. Hematology Study Section (NIH)	2.25	89,587
114. Human Embryology and Development Study Section (NIH)	2.00	80,800
115. Hypertension Information and Education Advisory Committee (NIH)	.45	12,600
116. Hypertension Research Centers Advisory Committee (NIH)	.10	20,000
117. Immunization Practices Advisory Committee (CDC)	.50	18,700
118. Immunobiology Study Section (NIH)	2.75	98,440
119. Indian Health Advisory Committee (HSA)	.12	10,440
120. Infectious Disease Committee (NIH)	1.00	16,000
121. Juvenile Problems Research Review Committee (ADAMHA)	1.50	46,240
122. Lipid Metabolism Advisory Committee (NIH)	.10	20,000
123. Long-Term Care for the Elderly Research Review and Advisory Committee (HRA)	2.50	77,419
124. Mammalian Mutant Cell Lines Committee (NIH)	.50	20,000
125. Maternal and Child Health Research Committee (NIH)	.50	14,000
126. Maternal and Child Health Service Research Grants Review Committee (HSA)	0	0
127. Medical Devices Advisory Committee (FDA)	0	0
128. Medical Devices Application Committee (NIH)	.10	8,000
129. Medical Laboratory Services Advisory Committee (CDC)	.20	12,000
130. Medical Radiation Advisory Committee (FDA)	.30	16,000
131. Medical Chemistry A Study Section (NIH)	2.25	88,295
132. Medicinal Chemistry B Study Section (NIH)	2.25	103,140
133. Mental Health Services Research Review Committee (ADAMHA)	1.25	51,251

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE—Continued

LIST OF ALL ADVISORY COMMITTEES AT THE BEGINNING OF CALENDAR YEAR 1974—Continued

	Estimated Man-Years of staff support	Estimated cost
134. Mental Health Small Grant Committee (ADAMHA)	3.50	133,140
135. Mental Retardation Research Committee (NIH)	1.00	32,005
136. Metabolism Study Section (NIH)	2.75	100,325
137. Metropolitan Mental Health Problems Review Committee (ADAMHA)	1.50	26,500
138. Microbial Chemistry Study Section (NIH)	2.50	79,960
139. Minority Mental Health Advisory Committee (ADAMHA)	0	0
140. Molecular Biology Study Section (NIH)	2.50	82,390
141. Molecular Control Working Group (NIH)	.40	15,090
142. Narcotic Addiction and Drug Abuse Review Committee (ADAMHA)	1.06	80,100
143. National Advisory Allergy and Infectious Diseases Council (NIH)	2.00	35,000
144. National Advisory Child Health and Human Development Council (NIH)	1.00	27,000
145. National Advisory Commission on Multiple Sclerosis (NIH) [1]	3.00	100,000
146. National Advisory Committee on the Handicapped (OE) [1]	1.00	4,487
147. National Advisory Council on Adult Education (OE) [1]	6.00	166,000
148. National Advisory Council on Alcohol Abuse and Alcoholism (ADAMHA) [1]	.60	30,050
149. National Advisory Council on Comprehensive Health Planning Programs (HRA) [1]	.23	12,392
150. National Advisory Council on Drug Abuse (OS) [1]	0	0
151. National Advisory Council on Education of Disadvantaged Children (OE) [1]	7.00	185,000
152. National Advisory Council on Education Professions Development (OE) [1]	3.00	150,000
153. National Advisory Council on Equality of Educational Opportunity (OE) [1]	4.00	150,000
154. National Advisory Council on Ethnic Heritage Studies (OE) [1]	0	0
155. National Advisory Council on Extension and Continuing Education (OE) [1]	3.00	100,000
156. National Advisory Council on Health Manpower Shortage Areas (HSA) [1]	.12	23,355
157. National Advisory Council on Health Professions Education (HRA) [1]	2.50	55,100
158. National Advisory Council on Health Research Facilities (HRA) [1]	0	0
159. National Advisory Council on Indian Education (OE) [1]	4.00	150,000
160. National Advisory Council on Nurse Training (HRA) [1]	1.30	65,089
161. National Advisory Council on Regional Medical Programs (HRA) [1]	.80	105,277
162. National Advisory Council on Services and Facilities for the Developmentally Disabled (SRS) [1]	1.50	51,717
163. National Advisory Council on Supplementary Centers and Services (OE) [1]	4.00	150,000
164. National Advisory Council on Vacational Education (OE) [1]	10.00	330,000
165. National Advisory Dental Research Council (NIH) [1]	.33	24,100
166. National Advisory Drug Committee (FDA)	.30	19,000
167. National Advisory Environmental Health Sciences Council (NIH)	1.00	39,571
168. National Advisory Eye Council (NIH)	2.00	29,965
169. National Advisory Food Committee (FDA)	.30	19,000
170. National Advisory General Medical Sciences Council (NIH)	.50	15,000
171. National Advisory Health Council (OS) [1]	0	0
172. National Advisory Health Services Council (HRA)	.60	17,419
173. National Advisory Mental Health Council (ADAMHA) [1]	1.00	25,000
174. National Advisory Neurological Diseases and Stroke Council (NIH)	1.50	58,300
175. National Advisory Public Health Training Council (HRA)	.20	6,132
176. National Advisory Research Resources Council (NIH)	1.00	20,200
177. National Advisory Veterinary Medicine Committee (FDA)	.30	16,000
178. National Arthritis, Metabolism and Digestive Diseases Advisory Council (NIH)	1.00	37,000
179. National Blood Resource Program Advisory Committee (NIH)	.30	19,000
180. National Cancer Advisory Board (NIH) [1]	2.00	65,000
181. National Council on Quality in Education (OE) [1]	0	0
182. National Heart and Lung Advisory Council (NIH) [1]	.80	68,922
183. National Medical Libraries Assistance Advisory Board (NIH) [1]	0	0
184. National Migrant Health Advisory Committee (HSA)	.60	31,995
185. National Professional Standards Review Council (OS) [1]	5.00	126,000
186. Neurological Diseases and Stroke Science Information Program Advisory Committee (NIH)	.50	22,300
187. Neurological Disorders Program-Project Review A Committee (NIH)	2.00	116,100
188. Neurological Disorders Program-Project Review B Committee (NIH)	0	0
189. Neurology A Study Section (NIH)	2.50	96,320
190. Neurology B Study Section (NIH)	3.00	114,920
191. Neuropharmacology Advisory Committee (FDA)	.30	13,000
192. Neuropsychology Research Review Committee (ADAMHA)	2.00	80,198
193. Nursing Research and Education Advisory Committee (HRA)	.90	32,948
194. Nutrition Study Section (NIH)	2.00	86,010
195. Obstetrics and Gynecology Advisory Committee (FDA)	.50	20,000
196. Oncologic Drugs Advisory Committee (FDA)	0	0
197. Opathalmic Drugs Advisory Committee (FDA)	.50	13,000
198. Panel on Review of Allergenic Extracts (FDA)	0	0
199. Panel on Review of Anesthesiological Devices (FDA)	.30	14,000
200. Panel on Review of Antacids (FDA)	.30	15,000
201. Panel on Review of Antimicrobial Agents (FDA)	.30	15,000
202. Panel on Review of Antiperspirant Drug Products (FDA)	0	0
203. Panel on Review of Bacterial Vaccines and Bacterial Antigens (FDA)	.30	23,000
204. Panel on Review of Bacterial Vaccines and Toxoids (FDA)	.30	45,000
205. Panel on Review of Blood and Blood Derivatives (FDA)	0	0
206. Panel on Review on Cardiovascular Devices (FDA)	.30	14,000
207. Panel on Review of Cold, Cough, Allergy, Brochodilator and Antiasthmatic Agents (FDA)	.30	15,000
208. Panel on Review of Contraceptives and Other Vaginal Drug Products (FDA)	.30	15,000
209. Panel on Review of Dental Devices (FDA)	.30	14,000
210. Panel on Review of Dentifrices and Dental Care Agents (FDA)	.30	15,000
211. Panel on Review of Ear, Nose and Throat Devices (FDA)	0	0

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE—Continued

LIST OF ALL ADVISORY COMMITTEES AT THE BEGINNING OF CALENDAR YEAR 1974—Continued

	Estimated Man-Years of staff support	Estimated cost
212. Panel on Review of Gastroenterology and Urological Devices (FDA)	0	0
213. Panel on Review of General Hospital Devices (FDA)	0	0
214. Panel on Review of General and Plastic Surgery Devices (FDA)	0	0
215. Panel on Review of Hemorrhoidal Drugs (FDA)	0	0
216. Panel on Review of Immune Serums, Antitoxins and Antivenins (FDA)	0	0
217. Panel on Review of Internal Analgesic Including Antirheumatic Drugs (FDA)	.30	15,000
218. Panel on Review of In Vitro Diagnostic Reagents (FDA)	0	0
219. Panel on Review of Laxative, Antidiarrheal, Antiemetic and Emetic Drugs (FDA)	.30	15,000
220. Panel on Review of Miscellaneous Biological Products (FDA)	0	0
221. Panel on Review of Miscellaneous External Drug Products (FDA)	0	0
222. Panel on Review of Miscellaneous Internal Drug Products (FDA)	0	0
223. Panel on Review of Neurology Devices (FDA)	0	0
224. Panel on Review of Obstetrics and Gynecology Devices (FDA)	0	0
225. Panel on Review of Ophthalmic Devices (FDA)	0	0
226. Panel on Review of Ophthalmic Drugs (FDA)	.30	15,000
227. Panel on Review of Oral Hygiene Drug Products (FDA)	0	0
228. Panel on Review of Orthopeadic Devices (FDA)	.30	14,000
229. Panel on Review of Pathology Devices (FDA)	0	0
230. Panel on Review of Physiatry Devices (FDA)	0	0
231. Panel on Review of Radiology Devices (FDA)	0	0
232. Panel on Review of Sedative, Tranquilizer and Sleep Aid Drugs (FDA)	.30	15,000
233. Panel on Review of Skin Test Antigens (FDA)	0	0
234. Panel on Review of Topical Analgesics Including Antirheumatic, Otic, Burn, Sunburn Treatment and Prevention Drugs (FDA)	.30	15,000
235. Panel on Review of Viral Vaccines and Rickettsial Vaccines (FDA)	.30	45,000
236. Panel on Review of Vitamin, Mineral and Hematinic Drug Products (FDA)	.30	15,000
237. Pathology A Study Section (NIH)	2.00	80,725
238. Pathology B Study Section (NIH)	2.50	109,220
239. Periodontal Diseases Advisory Committee (NIH)	.40	12,800
240. Personality and Cognition Research Review Committee (ADAMHA)	2.00	72,186
241. Pharmacology Study Section (NIH)	3.00	115,900
242. Pharmacology-Toxicology Program Committee (NIH)	.50	80,500
243. Physiological Chemistry Study Section (NIH)	3.00	93,280
244. Physiology Study Section (NIH)	2.00	80,420
245. Population Research Committee (NIH)	1.00	27,000
246. Population Research Study Section (NIH)	2.00	75,620
247. Preclinical Psychopharmacology Research Review Committee (ADAMHA)	2.00	59,801
248. President's Cancer Panel (NIH)[1]	.50	21,550
249. President's Committee on Mental Retardation (OS)	11.00	656,000
250. President's Council on Physical Fitness and Sports (OS)	.27	8,000
251. Primate Research Centers Advisory Committee (NIH)	.75	21,841
252. Public Health Conference on Records and Statistics—Standing Committee (HRA)	.75	24,818
253. Pulmonary-Allergy and Clinical Immunology Advisory Committee (FDA)	.30	13,000
254. Pulmonary Diseases Advisory Committee (NIH)	.15	30,000
255. Radiation Bioeffects and Epidemiology Advisory Committee (FDA)	.30	14,000
256. Radiation Study Section (NIH)	2.00	109,420
257. Radioactive Pharmaceuticals Advisory Committee (FDA)	.50	14,000
258. Reproductive Biology Study Section (NIH)	2.00	97,200
259. Respiratory and Anesthetic Drugs Advisory Committee (FDA)	.30	13,000
260. Safety and Occupational Health Study Section (CDC)	.20	33,600
261. Science Advisory Board-National Center for Toxicological Research (FDA)	.20	45,000
262. Secretary's Advisory Committee on Population Affairs (OS)	.15	35,300
263. Secretary's Advisory Committee on Rights and Responsibilities of Women (OS)	2.00	116,000
264. Sickle Cell Disease Advisory Committee (NIH)	.05	16,500
265. Social Problems Research Review Committee (ADAMHA)	1.25	41,077
266. Social Sciences Research Review Committee (ADAMHA)	2.00	53,970
267. Solid Tumor Virus Working Group (NIH)	.40	11,500
268. Surgery A Study Section (NIH)	2.00	74,860
269. Surgery B Study Section (NIH)	3.00	83,490
270. Surgical Drugs Advisory Committee (FDA)	.30	13,000
271. Task Force on Education and Training for Minority Business Enterprise (OE)	1.00	10,000
272. Technical Electronic Product Radiation Safety Standards Committee (FDA)	.50	14,000
273. Therapeutic Evaluations Committee (NIH)	1.00	16,000
274. Third National Cancer Survey Utilization Advisory Committee (NIH)	.02	500
275. Thrombosis Advisory Committee (NIH)	.23	9,500
276. Tobacco Working Group (NIH)	.80	11,000
277. Toxicology Study Section (NIH)	2.00	92,910
278. Transplantation and Immunology Committee (NIH)	1.50	14,000
279. Tropical Medicine and parasitiology Study Section (NIH)	2.00	80,020
280. Tuberculosis Control Advisory Committee (CDC)	.07	3,500
281. U.S. National Committee on Vital and Health Statistics (HRA)	.60	13,550
282. Venereal Disease Control Advisory Committee (CDC)	.05	7,600
283. Virology Study Section (NIH)	2.00	97,695
284. Vision Research Program Committee (NIH)	.40	43,650
285. Visual Sciences A Study Section (NIH)	2.00	82,420
286. Visual Sciences B Study Section (NIH)	2.00	82,420
Total estimated cost	514.57	12,414,050

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[1] Committee mandated by statute.

Mr. FLOOD. You might create a committee against creating more committees.

Secretary WEINBERGER. That is essentially what we have. We have a review process that not only reviews all of those in existence, but as the authorities and the charters expire, the burden of showing that the committee should stay in existence is on the committee itself. We don't renew automatically, and as a result we have managed to reduce, if my memory is correct, close to 150, maybe 125 of the existing committees we have. We had a tremendously large number, much too large for me to deal with and too large I think, for the Government to secure any real benefit from.

RELEASED 1973 FUNDS

Mr. FLOOD. Large sums of money have unexpectedly become available as a result of the release of impounded 1973 appropriations. Do you feel the Department is doing everything it can to make sure that these funds will be put to a pretty good use?

Secretary WEINBERGER. Yes, sir, we do. We have a couple of opposing forces pulling at that problem. One of them says, because the funds are released they all have to be spent, and the other one says, yes, they should be spent, but they should be spent wisely.

Frankly I am leaning heavily toward the second line of thought. We have no intention of trying to hold them back for purposes of economy or anti-inflation or anything of that kind. We are, however, very firmly conscious of the necessity to spend them wisely, and the fact that we may have $60 or $70 million available that can be spent prior to June 30 or prior to next February or whatever should not, in my opinion, be taken as an open invitation or an order that they have to be spent no matter what. I think you would want them spent wisely and for purposes that would advance us toward program objectives, and that is exactly what we are trying to do. But we are not withholding them for the sake of withholding them; we are not spending them for the sake of spending them.

Mr. FLOOD. On the matter of health, obviously you and I could discuss this health budget for days. We will have the Assistant Secretary for Health up here next week and we will give him the grilling. However, there are a few questions which I would like to ask you as well.

Secretary WEINBERGER. Yes, sir.

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

Mr. FLOOD. Do you think this PSRO proposition, Professional Standard Review Organization, is going to work? We are getting complaints from the M.D.'s as you know and from their patients. They have forms and cards in the outside office which they ask them to fill out and send down to the Members and protest vehemently and so on. These people think that the law which creates these PSRO's ought to be repealed. What about it?

Secretary WEINBERGER. Mr. Chairman, there are several things that should be said about that.

In the first place the PSRO statute was not an administration request. In the second place it was adopted by the Congress in October of

1972 as a result of a conference committee discussion on a bill that was called H.R. 1 at that time. There were no hearings and no general congressional discussion or debate on the subject.

We were faced with a very substantial administrative task. Contrary to what some might think, we do carry out congressional intent and we have been putting the PSRO program into place. We are on schedule in doing so.

It is a novel program. It has some very important purposes and goals, and one of those is to insure that quality medical care is delivered to people under the federally supported medicare and medicaid programs.

Another is to insure that there is a standard of proper quality care established throughout the country with due respect for differences in medical practice in the various parts of the country.

The third is that this is all to be done by a series of organizations staffed and run and led by physicians themselves. All of these are statutory provisions.

I would be less than candid if I did not express to you my feeling that there is a potential danger of very substantial governmental interference in the practice of medicine by this kind of statute. But it is there; it is on the books. We are making every effort to administer it in accordance with the intention of the Congress which, as we read it, was to have the doctors themselves actually run it with support and assistance from the Government and with a few preliminary steps being taken by the Government. Those preliminary steps have been taken. We have made the area designations. We have performed that task, which is roughly similiar to a congressional apportionment of the entire country because that is almost what the Congress asked us to do last year. That was a very big task. I have done it for one State and it is a very big job to do it for the 50 States.

But we have done that, and it is going to have the predictable result that there will be a few people who won't be happy with the designations. Those designations include 203 areas across the country, and were published in the Federal Register on March 10. Preliminary designations were published last December. We had a substantial amount of comment. We gave every consideration to that comment and consistent with the law made all of the changes we thought we possibly could.

We will expect to have in place 50 PSRO's in 1974. 70 additional ones in 1975. Proposals for contracts for planning, statewide support centers will be accepted beginning in April. We hope to have our first statewide support center, which I believe will be in Pennsylvania, in operation before June. At least the contracts will have been awarded.

This is a very large program, a major departure from previous governmental involvement in the practice of a profession. We are carrying out, we believe, to the best of our ability the intention of the Congress. We are on schedule. If the act should be repealed, that would be something that the Congress would propose.

I think it is fair to say we have to have something in place that gives us the opportunity to judge whether or not medical and hospital and health services performed under medicare and medicaid first of all have been done in a way that is consistent with high medical quality of care; secondly, whether they were necessary services.

There is a series of articles running now in a Chicago newspaper comparable to the series that ran in the Washington newspapers. They have listed the top 10 doctors in fees paid by the medicaid program in Illinois. The top is $482,000 for one doctor in 1 year. The bottom of this top 10 is somewhere in the neighborhood of $200,000, about $180,000. Payments of this kind at the very least raise questions as to whether some of the services were actually necessary and whether the Federal Government should have been billed for them or not. The PSRO program is not, as such, a cost control program. It does, however, give us the opportunity to get very necessary information to determine whether services were, first of all, of high quality and, second, whether they were necessary, whether they would be the customary kind of services. Thus when you see a bill claiming reimbursement for seven home visits in 1 day you can measure it against a standard established by the PSRO and see quite quickly that is unusual. The question can then be raised as to whether the Federal Government should reimburse all of those services.

We are also putting in place independent of the PSRO program hospital utilization review programs which are designed to tell us whether certain stays in the hospital were necessary or overextended. If so, too much money was being requested of the Federal Government consistent with the health needs of the individual.

So I would say, not briefly because it is not a question to be answered briefly, that the PSRO program is a program in which we are carrying out the intent of the Congress as we read it.

You are quite right it is very controversial. We have had a lot of criticism and a lot of unhappiness expressed by doctors about it. We are replying to them that the intention of the Congress is that they themselves run the program, and that we are to give support assistance and designate areas—and we have done the latter and are doing the former—and that we will enforce it as long as it is on the books. We will enforce it as vigorously and as ably as we possible can because it is a congressional enactment.

We will need something in any event to help us get control of health care costs and block the inflationary rise that we have seen in this area, particularly if we move into comprehensive health insurance. And we have in our comprehensive health insurance plan the reliance on various utilization review and PSRO type organizations to give us the information we need.

SUPPLY OF MEDICAL PERSONNEL

Mr. FLOOD. You say there is an oversupply of medical personnel?

Secretary WEINBERGER. No, sir.

Mr. FLOOD. Do you have any hard evidence which would support such a conclusion?

Secretary WEINBERGER. We say there may be if we increase very substantially the amount of Government encouragement and Government subsidy for additional education of various health care personnel. We propose continuing at the level of previous years the support for capitation grants and training of additional medical personnel, nurses, and so on. We do not believe we have any justification for a drastic increase in that number. We feel some should be phased down because we believe that as we look 7 to 10 years ahead, with the changes coming in medical practice, with the increased use of paramedical personnel, we may well get ourselves into a surplus position, and we want to avoid that obviously. However, we believe we should continue at the present level for the time being the degree of Government support in the form of capitation grants and other programs.

Our principal problem is to try to get medical personnel into underserved areas of the country. We hope to do that. We do have some reductions in capitation grants but they are designed to produce a level supply of governmentally assisted medically trained personnel.

Mr. **Flood** What about the NIH studies which indicate there is a shortage of some 30,000 doctors, and that supply and demand will not even out until sometime in 1985 or even up to 1990?

Secretary **Weinberger.** Mr. Chairman, we had occasion to comment on those studies last year. I would make the same response I did then, that the studies are based on a set of assumptions which I do not think are entirely correct or acceptable. These assumptions are that the medical practice, hospital practice, utilization, length of hospital stays, all stay relatively the same. There is no change in their assumptions. We don't believe that is a valid premise on which to base the need for studies of medical manpower or hospital or other health service personnel. We believe you have to recognize the fact that research is causing a continually changing picture.

For example, the treatment now for glaucoma has moved down from 10 to 11 days of hospitalization to $1\frac{1}{2}$ days. Indeed, as they say, it is medically contraindicated to stay in the hospital longer than that period of time. That is true of other diseases. This will make substantial changes in the number and type of personnel needed, in the kind of homecare required, in the kind of facilities required. This is only one of a great many other problems.

There is also an increasing reliance on the use of paramedical personnel, physician extenders, and so on. We have studies underway by the National Institute of Medicine which we believe will be based on a great deal more realistic set of assumptions and premises.

IMPACT OF NATIONAL HEALTH INSURANCE

Mr. **Flood.** Will not this proposed national health insurance create a tremendous increase in the demand for national health service, such as medicare, medicaid? Where will we find the doctors and the dentists and the nurses to provide such services?

Secretary **Weinberger.** Mr. Chairman, we believe we are on a path of producing right now an upward trend of more doctors, more nurses, and so on. We believe as the full impact of what undoubtedly will be increased requests for medical manpower under the Health Insurance Act is felt in the years ahead the increased number of medical personnel which are now coming on the line, so to speak, from medical schools which were supported with Government funds in earlier years will be sufficient to handle this increased demand for service.

We have higher enrollment levels right now, large increases in the number of active positions for dentists and nurses. Between [illegible] and 1985 the supply of physicians will increase by 50 percent, dentists by

40 percent, nurses by 60 percent. When you take into account—this is just with the levels of funding we have requested—the fact that you will have physicians performing fewer tasks than they are performing now, and more of these tasks performed by nonphysician personnel, we believe we are on the proper path and that we will come out, granted the increased demand for health services, in the 1980's and 1990's with the proper supply, not a surplus. We think there are real dangers to continuing to increase Government subsidy for health manpower training so as to produce major surpluses.

We did that with schoolteachers. We did it with space scientists. They caused serious dislocation problems when those surpluses were realized.

HEALTH MANPOWER LEGISLATION

Mr. FLOOD. In your statement you say your health manpower legislative and budget proposals seek to maintain the current level of training and focus greater attention on the problems of encouraging a better geographic distribution of medical personnel, increasing the proportion of new doctors trained in the delivery of primary care, making better utilization of paraprofessionals, and attracting more women and minorities into the health professions. These are admirable goals.

Can you tell us specifically which legislative proposals will achieve these goals and what budget proposals you have in mind specifically to accomplish these things? Tell us how these proposals would or would not do what you have in mind. Tell us how much and how many so that these programs will bring about the results you seek.

Mr. MICHEL. Mr. Secretary, are those figures you cite with respect to achieving these goals a result of manpower legislation on the books or will it require additional legislation which we do not have but which you have under consideration?

Secretary WEINBERGER. The latter. The proposals we have for health manpower development, carrying out our general goals which we have outlined and fitting within the budget appropriations we have mentioned, are under development now in the Department. They are the last major pieces of health legislation. We have submitted the health planning legislation and we have now under development nearly ready for submission the health manpower legislation. It would carry out these goals and it would, we believe, produce these numbers of doctors and nurses, and so on, which we believe will be necessary in the next 10 to 12 years. I expect these proposals will come up in ample time for enactment this year because it is necessary that this go along with our budget request.

PHASEOUT OF TRAINING PROGRAMS

Mr. FLOOD. Do you have any studies or data of any kind to support your phaseout policy with regard to all kinds of training? If so, suppose you let the committee have that.

Secretary WEINBERGER. All right, sir.

[The following was submitted:]

The Department has made no new formal studies of special manpower training programs. A two-volume study of biomedical research training programs was completed by NIH last year. We have, on an informal basis, reviewed the training terminations proposed in the 1974 budget and have proposed some revisions to that policy in the 1975 budget. For example, we are proposing to continue funding for postdoctoral biomedical research training, largely on the basis of data presented by NIH identifying shortages in some key disciplines and the fact that NIH aids over 50 percent of the persons involved in this type of training, a fact developed in last year's study. On the other hand, the study indicated a less critical NIH role in predoctoral training. For example, about 28 percent of graduate students received NIH training support and 90 percent of Ph. D.'s in the biomedical sciences either have no indebtedness at the end of their Ph. D. training or have loans outstanding of $3,000 or less.

We are also proposing to continue capitation support for veterinarians, optometrists, pharmacists, and podiatrists in the 1975 budget, rather than proposing to terminate this type of assistance as we did in 1974. Similarly, we would continue training for teachers of the handicapped, rehabilitation counselors, and teachers in bilingual education programs.

In general, our approach is to start or continue a specialized training program only where a real manpower shortage is identified and where Federal intervention is necessary to overcome that shortage. We are proposing to continue programs which can produce this type of data. If these essentials cannot be demonstrated, however, we are proposing either a gradual phaseout or termination. For example, we are proposing no new funding for degree training for social workers. It is our belief that welfare departments are experiencing no difficulty in recruiting graduates and that an adequate number of college students are electing this training and would continue to do so in the absence of the special Federal program. We also believe that this will be the case of schools of public health, allied health training, and nursing.

PROPOSED TERMINATION OF HEALTH PROGRAMS

Mr. Flood. Last year you proposed to terminate or phaseout a number of health programs.

Secretary Weinberger. Yes, sir.

Mr. Flood. Including the regional medical programs, Hill-Burton grants, and mental health centers.

In the face of your recommendations, the Congress, by nearly unanimous votes in both Houses, extended the authorizations for all of these programs for another year. This year you seem to be making the same proposals.

Secretary Weinberger. Not all of the same proposals, Mr. Chairman. We are making some of the same proposals.

Mr. Flood. What makes you think you will get a better reception this year than you did last year?

Secretary Weinberger. Well, I suppose unquenchable optimism might be one factor. I would point out, Mr. Chairman, that the extension of the authority by the Congress was not, I think, accompanied by an intent that all of those programs were to be kept in place permanently. The extension legislation as I recall the debate at that time was that the Congress was not ready to accept the recommendations for abolition but that the Congress did feel that it needed more time to consider the proposals in detail. You are certainly quite right about some of them, but I thought that the blanket extension of authority was to give more time to consider it.

The President has carried out his responsibilities in the sense that he has recommended again eliminating some of the programs that were extended for 1 more year because he believes very strongly that some of these programs should not be continued, and those are reflected in the recommendations that appear in his budget.

Some he has recommended be transferred or carried out in other ways, rather than not being funded.

SUPPLY OF HOSPITAL BEDS

Mr. **FLOOD.** What concrete evidence do you have that there is an over supply of hospital beds?

Secretary **WEINBERGER.** That is straight sets of figures and straight data, Mr. Chairman. I have heard very few people ever dispute the fact we have a national surplus of a very substantial amount which leaves the Hill-Burton program in the administration's eyes completely unwarranted.

Mr. **FLOOD.** How would you deal with this matter of modernization and replacements of obsolete hospitals?

Secretary **WEINBERGER.** Let me give you a few of the figures that I mentioned and then I will discuss some of the other arguments.

The Hill-Burton expenditures have now exceeded $4 billion since the program started.

We have an occupancy rate in hospitals varying from 66 to 80 percent or, in other words, a vacancy rate of 20 up to 35 percent.

We have had a growth in the beds per thousand population of 3.6 beds per thousand up to 4.3 beds per thousand.

Mr. **MICHEL.** In what timeframe?

Secretary **WEINBERGER.** Since the Hill-Burton program has been in effect, from 1960 through 1972.

Mr. **YOUNG.** Those numbers are from 1961 through 1971.

Secretary **WEINBERGER.** All right. The availability—you asked how I would handle it.

Mr. **FLOOD.** Yes.

Secretary **WEINBERGER.** The availability of other funds is a very significant factor, Mr. Chairman. Private insurance carriers now make payments to hospitals for patient care which includes reimbursement for capital expenditures for replacement of existing facilities. In 1974 this totaled over $1 billion.

The Federal Government itself, through the medicare-medicaid payments, makes similar payments totaling almost $800 million, so you have $1.8 billion for this specific purpose.

COMMUNITY MENTAL HEALTH CENTERS

Mr. **FLOOD.** What data do you have to support your conclusion that there are enough community mental health centers in the United States?

Secretary **WEINBERGER.** Again, Mr. Chairman, two things—the tremendous growth of these is one. There are in excess of 625 community mental health centers supported or funded with Federal funds. This has been a rather rapid growth rate over the past few years.

The other thing is that the program has been designed from the beginning as a program which would provide Federal funds for the first 5 years—and then ultimately 8 years—to the mental health centers which were to be started, organized, and ultimately run by the community, hence, the name, community mental health centers.

It never has been contemplated that the Federal Government pay the operating expenses of these centers permanently. It was a demonstration program designed to show that, with Federal funding for a 5 and ultimately an 8-year period, this kind of center could work.

I happen personally to be very interested in this because I was in the California Legislature when we initiated a program long before there was any Federal support, so I knew from that experience that it would work, that you could run community mental health centers with State and local financing without Federal funds at all.

Certainly now, after 9 years, and 626 of these centers in operation, you have a complete demonstration of the fact it works. Therefore, we think that it is time for Federal funding to be phased out, as was the original intent of the Congress, and that the demonstrated success of the program will be clear to those communities which may wish to continue it.

NIH GRANTS REVIEW PROCESS

Mr. FLOOD. Over the years we have watched the operation of the NIH peer review system for the review and approval of research and training grants. We think it has worked pretty well. In fact, we have been asked why it has not been applied to other HEW areas. Do you have any plans to do away with the peer review system, or to alter or improve this?

Secretary WEINBERGER. We believe it can be strengthened. We certainly have no plans to terminate it. We never have had. There have been some misconceptions around, again in various articles by people who have not bothered to ascertain the facts, but the simple fact is that we have no desire, and never have had, to terminate it. We believe it can be strengthened and improved, as can most programs.

FEDERAL SHARE OF NATIONAL EXPENDITURES FOR ELEMENTARY AND SECONDARY EDUCATION

Mr. FLOOD. The Federal Government now provides about 7 percent of the total national expenditures for elementary and secondary education.

Secretary WEINBERGER. Yes, sir.

Mr. FLOOD. And former Assistant Secretary Marland and many educational organizations have advocated increasing this to 25 percent. Do you agree that this is the direction in which we should be moving?

Secretary WEINBERGER. No, sir, I am not aware that former Secretary Marland ever took that position, either. I never heard him take that position. I am not in favor of it.

Mr. FLOOD. Why not?

Secretary WEINBERGER. Because, Mr. Chairman, for one thing I think the funding and operation of the public school system should remain essentially a local responsibility. I think our school system has grown up over the years to be one of the best in the world because of local control. I think that has had a lot to do with it.

I think the Federal funds that go into the public school system are very substantial now and I would certainly like to see what the additional funding would be used for before I endorsed any such blanket proposition that instead of 6 or 7 percent the Federal Government should provide something close to 25 to 30 percent. I don't believe there would be any countervailing reduction of the local funding going into schools if that increase were made. I think we would be engaged in a rather continual game of trying to keep our percentage of Federal contributions at the "right figure" while overlooking completely what the funds were actually used for.

Most large increases in public school funding go for increased salaries for the personnel already in place. It has not been demonstrated to me how that improves the quality of the teaching or of the education.

There are certain areas where substantial increases are needed. We have tried to address those in our so-called national priorities. I believe the Education Act that [illegible] working its way through the House now contains many of these elements which we believe are a proper national priority.

THE BUDGET FOR ELEMENTARY AND SECONDARY EDUCATION

Mr. Flood. The budget authority requested for fiscal 1975 for elementary and secondary education is $3,583,000,000. That is a reduction from $3,891,000,000 appropriated for 1974 and $4,245,000,000 for 1973. This reduction is of course, much greater than the figures would indicate, because of inflation.

Secretary Weinberger. There are two points, Mr. Chairman.

Mr. Flood. I am considering inflation. How can we justify providing less, rather than more, Federal support for elementary and secondary education?

Secretary Weinberger. Mr. Chairman, there are two problems here. One I mentioned earlier. We have asked for double-year funding in 1974 which will tend to inflate that figure and make any figure for 1975 be a reduction. That is one point.

Second, as I mentioned in my statement, we have requested again, as the last four Presidents have, that the impact aid funds for category B be phased out on the ground that spending a substantial amount of Federal funds for children whose parents work for the Federal Government is not a very adequate or equitable basis for the allocation of scarce Federal funds if you are interested in improving education generally through funding national priorities. Thus there is that reduction in our 1975 request.

Otherwise we have requested increases, and we have requested forward funding in 1974 in the form of a supplemental to be sent up as soon as authorizing legislation is signed. That will tend to distort the figures for 1974 and a computation of what 1975 is in relationship to 1974.

There is also, Mr. Chairman, Secretary Carlucci reminds me, a decrease requested for ESAA because of the fact that we believe many of the desegregation problems addressed by that act in its original scope have been improved substantially and that, therefore, the total amount needed is less.

ROLE OF FEDERAL GOVERNMENT IN EQUALIZING EDUCATIONAL EXPENDITURES

Mr. Flood. Do you think the Federal Government should take an active role in equalizing expenditures for elementary and secondary education among school districts and among States? This is the point I am getting to—take an active role so that children in all sections of the country have equal educational opportunity?

Secretary Weinberger. I believe the equalization process should be done at the State level and that the Federal Government should put its funds for elementary and secondary education into certain high priority national programs, or into bloc grants, as we originally proposed last year, which enable States and school districts to carry out their own priorities.

We have been willing to compromise on several of the details of that but basically we think that the equalization should be done within the States to allow children equal educational opportunities within each State. That has been the practice in many States, the practice in my State, and I think it has worked well.

What we have to do nationally is to use the Federal funds, the roughly 5, 6, 7 percent, whatever it turns out to be, of the total educational picture, for addressing high national priorities, or for aiding school districts to carry out their own priorities by giving them funds free of several of the narrow categorical boundary lines which tie them down now.

SENATE BILL FOR ELEMENTARY AND SECONDARY EDUCATION

Mr. Flood. You mention in your statement that the Senate version of the Elementary and Secondary Education Bill would be clearly unacceptable to the President.

Secretary Weinberger. Yes, sir.

Mr. Flood. Can you tell us more specifically what is in this bill which will make it objectionable?

Secretary Weinberger. I will do it in a couple sentences, which I know will be a relief to you, and then I will answer in a general way.

Then I will ask Mr. Carlucci, who has been involved in the day to day negotiations with both Houses regarding these bills, to spell out in more detail the problems with that bill. First, it does not move toward the categorical dissolution that I would like——

Mr. Flood. All right. What was I asking?

Secretary Weinberger. Why the Senate bill was unacceptable. I was going to tell you in general terms and then I would ask Mr. Carlucci to spell it out in detail. In general terms it does not have anywhere near the dissolution of the categorical boundary lines which we think are absolutely essential. In fact, it opens up some new programs, new categories, based on priorities or an allocation of Federal funds which we think would distort the actual need very substantially.

Mr. Carlucci has been involved in these negotiations and he can answer in more specific detail.

Mr. Carlucci. Among other things, Mr. Chairman, it would create some 15 new organizational entities in the Office of Education, most of which we consider unnecessary and irrevelant to the purposes of the bill.

In addition, the consolidation package is essentially an optical illusion in that it provides for a consolidation only after 100 percent of full funding of existing programs in a categorical mode and then only——

Mr. Flood. Provides for what?

Mr. Carlucci. Consolidation only after 100 percent full funding of existing programs in a categorical mode, and then only 50 cents of every additional dollar can be consolidated.

Finally, instead of phasing out the impact aid program—it does have some phaseout aspects for impact aid, categories A and B—it also would force funding of impact aid category C, children in public housing projects. We have very substantial problems with that bill, Mr. Chairman.

EARLY APPROPRIATIONS FOR EDUCATIONAL PROGRAMS

Mr. FLOOD. We are very concerned about this matter of late appropriations. We have knocked out our brains to do something about this, especially for the elementary and secondary education programs.

Secretary WEINBERGER. Yes, sir.

Mr. FLOOD. Last year our committee was able to achieve passage of this HEW appropriation bill by the House of Representatives before the beginning of the fiscal year.

Secretary WEINBERGER. That is right.

Mr. FLOOD. We would love to be able to do this again. We also included a floor provision relating to title I of ESEA grants in the continuing resolution so that the school districts would know how much they would be able hopefully to get before the beginning of the term. This we could have done, but fortunately the bill did not clear the other body until October, and the title I formula was changed five or six times before the appropriation bill was finally enacted on December 18. For a variety of reasons beyond our control, it just did not work out.

Secretary WEINBERGER. That is right.

Mr. FLOOD. This year, the outlook for early appropriations is no better, because the authorizing legislation has not been enacted. What are we going to do about that?

Secretary WEINBERGER. We certainly share the feeling that the bill should be passed as soon as possible. We appreciated very much the rapidity with which this subcommittee worked last year. We would hope that the same results can follow this year.

As soon as we get an authorization, as soon as we know what the ESEA bill will be, of course we will send up a supplemental that will enable us to get funding for the school year of 1974 and 1975. We have both our supplemental and budget appropriation geared to do that.

We would not favor any kind of continuing resolution or continuing hold-harmless clause which would keep the existing formulas going because we have grave doubts as to the propriety and validity of those formulas today, and also we believe that that would simply continue the existing program which has far too many categories in it.

We would like to get a formula which is roughly like the one the House committee has reported and have it enacted in time to submit a supplemental and get our budget request. We certainly would cooperate with you in every way to get the bill through as early as possible.

PROGRAM EVALUATION

Mr. FLOOD. Section 513 of the Public Health Service Act authorized the Secretary to spend up to 1 percent of any appropriation for grants, contracts, or other payments under this act for evaluation. Can you tell me how much you will spend in 1974 for evaluation of health programs and how much do you plan to spend in 1975 for evaluation?

Secretary WEINBERGER. In 1974 we plan to obligate $25.7 million for evaluation of health programs, and to maintain approximately the same spending level in 1975. I have a table which shows the amounts available for evaluation from 1973 to 1975. The estimates are maximums and include funds to be retained by the operating program. I will be glad to submit this table for the record.

[The information follows:]

EVALUATION FUNDS AVAILABLE FOR HEALTH, FISCAL YEARS 1973-75

[In thousands of dollars]

Agency/appropriation	Fiscal year— 1973	1974	1975
CDC	1,601	1,345	1,378
HSA	9,867	7,975	7,824
NIH	17,625	17,482	18,349
ADAMHA	8,037	7,930	6,922
HRA	12,421	11,136	5,739
Total, health	49,551	45,868	40,212

Mr. FLOOD. How much has been spent for evaluation studies in the past 10 years?

Secretary WEINBERGER. The Department has obligated approximately $189.1 million for evaluation studies between fiscal year 1966 and fiscal year 1974. Earlier comparable data is not available.

I have a table that I can submit for the record which shows detailed breakout by agency for amounts obligated from fiscal year 1969 to fiscal year 1974 for evaluation.

[The information follows:]

AMOUNTS OBLIGATED FOR EVALUATION OF DHEW

[In millions of dollars]

Agency and authority	Fiscal year— 1969	1970	1971	1972	1973	1974
Office of Education:						
Planning and evaluation	1.2	9.5	12.5	11.2	10.2	5.2
Follow Through	4.4	4.2	7.2	2.9	4.2	3.4
Emergency school assistance			1.5	1.0	3.3	2.5
Subtotal	5.6	13.7	21.2	15.1	17.7	11.1
Social and Rehabilitation Service:						
Vocational rehabilitation	.6	.7	1.0	.9	.4	1.0
Developmental disabilities			.1	.3	.1	.4
Work incentives [1]	1.0	1.8	1.8	1.8	1.8	1.8
Subtotal	1.6	2.5	2.9	3.0	2.3	3.2
Office of Human Development:						
Aging			.3	.3	.5	2.1
Child development	(2)	2.5	2.3	2.5	3.0	3.0
Youth development		.1	.2	.1	.1	.1
Subtotal		2.6	2.8	2.9	3.6	5.2
Health: [3]						
Office of the Secretary, Assistant Secretary for Health, and regions			1.3	3.0	3.5	3.8
Health Resources Administration			1.3	2.7	2.5	6.4
Health Services Administration			3.5	5.7	3.9	6.7
ADAMHA			2.5	3.1	2.9	2.8
Center for Disease Control			.2	.6	.1	1.0
National Institutes of Health				1.3	1.8	5.0
Food and Drug Administration [4]						
Subtotal [5]	(2)	4.7	8.8	16.4	14.7	25.7
Total	(6)	23.5	35.7	37.4	37.3	45.2

[1] Jointly administered by Departments of Labor and HEW.

[2] Not available.

[3] By administering agency; virtually all projects are authorized by sec. 513 of the PHS Act. Breakdowns for earlier years are not available in terms of current Health organization.

[4] FDA evaluations are conducted almost entirely from in-house resources under FDA authority.

[5] 1974 estimate is maximum approved. Some slippage will be returned for program operations. Total availability in health is considerably higher than approved plans or expected obligations, e.g., about $45,000,000 in 1974.

[6] About $10,000,000.

Mr. Flood. Can you explain to this commitee what your overall strategy is for the investment of these funds in fiscal 1974 and 1975?

Secretary Weinberger. The overall strategy for our evaluation effort is to develop a comprehensive understanding of our programs which will allow us to make improvements. We attempt to cover our programs across-the-board and in a given year plan the selection of programs for evaluation by anticipating the need for information on expiring programs as required by Congress and the administration. This judgment is tempered by the extent to which particular information will be useful in making decisions and the ability of the studies to develop information.

Mr. Flood. In which areas are you concentrating your evaluation efforts?

Secretary Weinberger. We plan to initiate over 300 evaluations in fiscal year 1974. Of these, about two-thirds will relate to health programs. Health studies will cover questions ranging from the adequacy of existing program data collection, to the actual effects of our programs on the health status of target populations, to comparisons of costs among different types of delivery systems, to the effectiveness of program and project management, and so forth. Because there are so many health programs, and so many types of evaluation questions to be answered for each program and across programs, we are still a long way from filling all the gaps in our knowledge.

The other big group of evaluation studies is in the education area. In 1974 we will continue to emphasize evaluating the impact and effectiveness of major Office of Education administered programs. We will cover areas such as postsecondary, elementary, and vocational education. To date evaluation studies on about two-thirds of our approximately 100 education programs have been initiated. In both 1974 and 1975 our basic strategy is to complete the evaluations we have underway, and to initiate studies on the remaining important programs. Finally, there are a much smaller number of evaluation studies, in the social services and human development areas. Here too we will focus on impact and effectiveness measurement targeted to key programs. For example, we plan to get at the relative effectiveness of the vocational rehabilitation program when the severity of the disability is taken into account.

Mr. Flood. Can you share with us now some of your major findings from the studies which have been completed in the last 12 months?

Secretary Weinberger. There have been a number of signifiicant findings related to evaluation studies in the past 12 months. I have a list to submit for the record which illustrates some of the major findings.

[The information follows:]

Education

Emergency school assistance program (ESAP-II) evaluation by NORC.—This study found that the program increased student achievement for one important segment of the target population, black high school males. Findings about successful programs were used to provide guidance to program officers for the fiscal year 1974 grant application review process.

Development of an interest subsidy and default projection model.—This study collected new data and analyzed defaults in student loans in order to build a model to project default rates more accurately. The study also pointed the way toward needed improvements in claim and collection activities, toward an improved information system and toward increased analysis of student loan activity.

Study of the developing institutions program.—From this study and a number of smaller related efforts, the concept of the advanced institutional development program (AIDP) was established. The AIDP helps expedite the development of selected institutions which have demonstrated positive trends within the basic grants portion of the program. Such institutions are awarded significantly larger grants and receive multiyear funding up to 5 years. Study results were also used as the program moved toward implementation. The elements of a planning and management system were denfined and a methodology for selecting institutions for the advanced program.

Social services and human development

Evaluation of the title IV–A traineeship grant program.—A survey of students from universities participating in the AOA title V (currently title IV–A) program was conducted to determine the effectiveness of the grants program and provided results concerning the program completion and success rate. Among the traineeship grant recipients in the aging studies programs, 82 percent completed their training programs. The program success measure was defined as the number of recipients who are currently working in jobs dealing with the elderly or their concerns. Sixty-three percent of the respondents met this criterion.

Followup study of recipients receiving vocational rehabilitation services.—A survey of 4,200 persons who received VR services from three test States (including California, Illinois, and Pennsylvania) provided the following findings:

Of the persons who received training, 50 percent said that the training did not help them become or stay employed.

Of the persons who obtained employment, 38 percent indicated that they do not use their training at all in their current job.

Of this same group, 80 percent indicated that they could have gotten their current job without this training.

When asked how they obtained their first job after case closure, only 11 percent indicated that they received help from their VR counselor.

Health

Family planning.—A study was completed in June 1973, of 31 family planning projects funded by OEO/HEW. Findings from the study include:

Annual average cost per patient enrolled in family planning projects is directly related to patient load of the project.

	Per patient cost	Number of projects
Patient volume:		
Up to 950	$100	15
951 to 3,000	74	15
More than 3,000	42	15

There was considerable improvement in contraceptive use before and after program experience; a fairly high level of improvement continued after dropping out from the program.

High satisfaction with project experience was reported.

New careers.—A study of new careers projects has demonstrated that paraprofessionals can perform effectively (and earn promotion) in mental health settings at significantly lower cost than professional personel performing similar tasks.

Funding sources for CMHC's—A study of alternative sources of funds for CMHC's has found that most centers require considerable assistance in locating non-Federal funds if they are to maintain comprehensive service capacity.

Quality of care at neighborhood health centers.—Onsite assessments were conducted at neighborhood health centers supported by Federal funds. Basic findings from these reviews and from published reports indicate that the quality of care delivered at NHC's compares favorably with, but slightly lower than, care delivered by categorical programs such as maternal and infant care programs. Neighborhood health centers provide somewhat better service than outpatient departments which are a major source of care for low-income individuals particularly in urban areas. The NHC care is comparable to that provided by other institutional practitioners.

Mr. FLOOD. Have you ever gotten an evaluation study which recommended the termination of a program?

Secretary WEINBERGER. A good evaluation is generally aimed at program strengths and weaknesses, with the decision to terminate a program made by responsible program officials as a result of the findings. For example, the response to a negative evaluation might as easily be to redirect the program toward a strategy that does work or is more cost-effective as to terminate the program. Conversely, a study may show that a program has met its objectives well, and therefore the proper conclusion may be to end the program.

Many studies, of course, provide findings severely critical of our programs but stop short of recommending termination. For example, the Battelle Memorial Institute study of school assistance in federally affected areas, which we have cited to you in prior years, is of this type.

There are only a few cases in which studies have actually recommended termination of a program. For example, the National Bureau of Standards study of the title I formula, did in fact recommend termination of parts B and C of ESEA title I. An in-house study in 1971 by the Center for Disease Control concluded that there is risk of serious reaction and death from smallpox. This study recommended termination of small-pox vaccination programs funded, in part, by 314(d). A subsequent study has shown that the recommendation was followed and that resultant savings in public and private costs of vaccination and of illness caused by vaccination are in excess of $60 million annually.

Mr. FLOOD. Can you provide for the record a list of evaluation projects funded or to be funded in 1974? We would like a one paragraph description of the objective of each project.

[The information follows:]

This is not a final list of projects funded, but a list of projects which have been planned for probable implementation, depending on detailed design work. A few projects may be added that are not on this list. A number of the projects listed will be dropped, since final design work, internal reviews, or reviews of proposals may show that a planned study cannot be effectively implemented or will not be useful.

The attached listing is organized by administering agency.

1974 EVALUATION PROJECTS--OFFICE OF EDUCATION

A Large Scale Evaluation of Compensatory Reading and Reading Related Efforts in the Elementary Grades (continuation): This major study is assessing the effectiveness of compensatory reading programs under ESEA Title I funding available to economically disadvantaged students.

Longitudinal Study of Demonstration Programs (continuation): This is a study of the effects of large scale, intensive innovative efforts on the achievement and motivational levels of the same students over a three year period. Most programs were initially supported by Title III, ESEA, and involve some 21,000 students in 15 school districts.

Analysis of Base Year Data of the Vocational Impact Project (continuation): This study, which is part of a national longitudinal study of high school seniors, is aimed at assessing what is currently known about program impact and how well the State grant mechanism functions to implement the priorities of the 1968 Vocational Education Amendments. The study also is examining program gaps and duplications as a means to better coordination. A national survey is also under way to provide a quantitative description of vocational students, outcomes and services.

Assessment of School-Supervised Work-Education Programs (continuation): The objectives of this study are: 1) to analyze and compare programs which have work experience components; 2) to examine the purposes of various work-education programs in order to determine similarities and differences; 3) to assess experiences and services present in successful work-education programs; and 4) to identify limitations on carrying out work-education programs and to determine under what conditions work-education programs may be expanded.

Study of Alternative Models of a Guaranteed Student Loan Program (continuation): This study is formulating several alternatives to the present Guaranteed Student Loan Program (GSLP). The GSLP has come under criticism with regard to the nature of the repayment burden on borrowers (short term fixed amounts). The alternatives include a variety of flexible repayment terms and require estimates of costs and benefits to borrowers, lenders and Federal and State agencies.

A Longitudinal Evaluation of the Emergency School Aid Act Pilot Program (continuation): This study is evaluating the national impact of the Emergency School Aid Act Pilot Program on a nationally representative sample of minority students. Objectives of the study include: 1) evaluating the cumulative effects of different types of treatments under various exposure durations; 2) determining the differential effectiveness of local programs; and 3) comparing successful local projects to similar but unsuccessful projects in an effort to determine the difference between success and failure.

Evaluation of the Emergency School Aid Act General LEA Program (continuation): The objectives of this study are: 1) to determine the overall effectiveness of the program in achieving goals and objectives specified in the Emergency School Aid Act; 2) to determine the relative effectiveness of different activities funded under the General LEA (local education agency) Grants Program, and 3) to examine the conditions under which activities are effective.

Evaluation of the Follow-Through Program (continuation): The Follow Through Program has fostered development and implementation of a variety of approaches to early childhood compensatory education. The main purpose of this evaluation is to assess the effectiveness of these alternatives.

Impact Evaluation of the Bilingual Program, ESEA, Title VII: The Bilingual Program has been in operation for five years and its overall impact on children in this program has never been studied. Nor has the nature of the program (demonstration and/or service) ever been clearly established. Although there is anecdotal and impressionistic information that the program is effective, a factual objective study is greatly needed to determine effective program models.

Analysis and Synthesis of Recent State ESEA Title I Evaluation Reports and Development of a Model for State Evaluation Reports:
Studies at the national level on the effectiveness of ESEA Title I have been hampered by the lack of valid comparable data that could be aggregated across State boundaries. Similarly the data relating achievement gains and per-pupil expenditures is unclear. The purpose of this study is to analyze State Title I reports for evidence of effectiveness successful approaches, relationships and trends, and also to design standardized reporting procedures and formats which will provide for valid, reliable comparable data for evaluation and planning purposes.

Evaluation of Adult Education Special Projects Program: The Special Projects Program designs new experimental and demonstration projects aimed at discovering more effective means of motivating and teaching undereducated adults. It is necessary to assess the impact of these projects in promoting change in the ongoing basic education programs and the extent to which results have been disseminated in order to establish new priorities and budget levels.

Evaluation of Right-to-Read Community - Based Program. There are a large variety of community-based projects which vary greatly in type of organization funded, target population, methodology, instructional time sequences, etc. It is necessary to determine which type of project is most effective in serving its particular target population so that the results can be disseminated.

Study of Impact of Federal Student Aid Programs. Student assistance has become a major Federal thrust with a number of new programs being introduced by the Education Amendments of 1972. The number of students and new institutions participating in Federal aid programs is increasing and the need to assess the impact of the Federal programs on students and institutions is urgent. The primary purpose of the study is to examine the adjustments made by institutions in response to the new Federal funding patterns and on the ways in which students now finance their education.

Study of the Higher Education Act, Title III Developing Institutions Program. This will be used to assess the impact of the Title III program and to assist judgements on the validity of proposals submitted under this program.

Evaluation of Civil Rights Act Title IV. The Civil Rights Act Title IV program has been frequently criticized for poor administration and questionable projects. Beginning in FY 74, the program will operate under substantially revised regulations to reflect a new role for Title IV in providing technical assistance to desegregating school districts not provided under the Emergency School Aid Act. This study is designed to provide new information on Title IV projects by describing and analyzing a representative sample of projects and their characteristics.

Survey of Borrowers and Lenders in the Federal Insured Student Loan Program (continuation): This study is collecting data on defaults in student loans in an effort to construct a default estimating model. The model will be integrated with an existing higher education enrollment projection model.

Private Accrediting and Public Funding (continuation): The purpose of this study is to analyze and evaluate the present procedures for determining institutional eligibility for Federal financial assistance. Special attention is being given to reliance upon accreditation.

1974 EVALUATION PROJECTS--SOCIAL AND REHABILITATION SERVICE AND OFFICE OF HUMAN DEVELOPMENT

OYD

An Evaluation of Key Variables in the Development of Viable Youth Services Systems: An assessment of the key variables determining whether a local Youth Service System attains its goal of coordinating, improving, and institutionalizing services provided to youth in a community.

OCD

An Evaluation of the Head Start Improvement and Innovation Effort: An inquiry into how successful the effort to upgrade local HS management and performance has been.

A Longitudinal Evaluation of HS Using Social Competency Measures: The second phase of a study which will eventually measure impact of HS on the "social competency" of children, meaning their social and physical as well as intellectual development.

An Evaluation of Impact of Suspended HS Fee Schedule: An inquiry, at Congressional request, into the impact of the fee schedule on non-poor participation rates, its costs, and the reasons for local discontent with it.

Reduction of Head Start Audit Exceptions: An effort to reduce the incidence of HS grantees which do not meet all audit requirements, and an assessment of this effort.

An Evaluation of Head Start/Medicaid EPSDT Collaboration Project: An evaluation of how well the project is providing EPSDT services to Medicaid-eligible children, with corresponding savings to HS, and why.

An Evaluation of Handicapped Effort in the HS Program: An assessment of HS services to handicapped children (mandated by Congress), including development of an information system and cost estimates for these services.

An Evaluation of Project Development Continuity: A description of demonstration projects using two different program models; also an identification of critical variables and development of test instruments for a later evaluation of the models.

A Formative Evaluation of the Child and Family Resource Program: An assessment of the services being provided to CFRP families, and development of a reporting system, program models, and cost-effectiveness analyses for the program.

A Feasibility Study and Design for the Child and Family Resource Program Summative and Follow-up Evaluation: An inquiry into whether evaluation and follow-up studies of CFRP are possible and, if so, development of a design for them.

Planned Variation Follow-Through Study: A comparative analysis of longitudinal evaluation data of the Planned Variation program vs. regular Head Start, vs. no Head Start, each alternative with and without Follow Through.

Evaluation of the Home Start Program: An assessment the effectiveness of Home Start demonstration projects and derive from them program models and cost-effectiveness estimates for wider application.

Evaluation of Parent and Child Center Advocacy Components: An assessment of the advocacy aspect of the PCC's, which provide integrated services to poor families with children under 3.

An Assessment of OCD Programs Serving Children 0-3: PCC's and PCDC's: A determination of what has been learned from the PCC and PCDC research and demonstration projects, what more could be learned, and what the future role of these projects should be. The general issue is how well these programs, which use parents as developmental agents, meet the developmental needs of very young children.

An Evaluation of Training and Technical Assistance Program: An evaluation of whether the program is meeting its goals of training better Head Start staff and, generally, building local capacity in the area of children's services. Is the present, decentralized organization of the program effective?

Vocational Rehabilitation

Impact Evaluation Based on the Self-support Objective: An assessment of the impact of the VR program on handicapped individuals to support themselves through employment.

Follow-up Evaluation of Former VR Recipients: Inquiry of the extent to which VR services were adequately provided and benefit of these services to recipients over an extended period of time.

Description of the Disabled Population: A determination of the size of the universe of need, the VR services required by this population, and the relationship between the success of VR services and the socio-economic and disability characteristics of clients.

Measurement of the Impact of Non-employment Outcomes: A development of a model to measure the effectiveness of the non-employment benefits of the VR program.

Evaluation of Training Requirements for Rehabilitation Specialists and the Impact of the Current Federal Policy: A determination of the demand for rehabilitation personnel, and an assessment of the impact of the current Federal policy for training rehabilitation specialists.

AoA

Evaluation of State Agencies on Aging: An assessment of the effectiveness of State Agencies in performing their planning and coordination functions.

Utilization Manual for Older Americans Status and Needs Assessment Survey: A manual for State and Area Agencies to assist them to use the results of the Older Americans Status and Needs Assessment Survey in planning, evaluation, legislative relations, coordination with other agencies and public relations.

Manual and Training in Objective Setting: The development of a manual and training curricula to assist programs and projects to establish meaningful objectives and to monitor their progress against those objectives.

Area Agencies on Aging Self-evaluation Tool: A development of a system which will allow Area Agencies on Aging to determine whether individuals are receiving integrated and comprehensive services; service delivery organizations are providing the mandated services; and recipients are receiving the type and quality of services needed.

Methodology for Evaluation of Area Agencies on Aging: A development of a methodology for evaluating progress in action programs for coordination of existing services and for strengthening and continuing the planning process.

Evaluation Tool for Nutrition Project Use: A development of evaluation systems and tools to evaluate the quality of the services of nutrition projects.

AoA Data Base: An information collection and retrieval system of data on the elderly necessary for effective evaluation and planning of programs for the aged.

Strategy Evaluation for the Establishment of a National Clearinghouse on Aging: A plan for the development of an AoA Clearinghouse.

Evaluation of Research and Demonstration Utilization under Title IV: An identification of those characteristics of AoA R&D projects which influence utilization of their outputs and of those dissemination techniques which enhance the likelihood of utilizing R&D project findings, and an assessment of the extent to which the findings of projects funded under Title IV have been utilized.

DD

Development of an Evaluation Methodology for the Developmental Disability Program: A determination of the goals and objectives of the program and a development of criteria to assess the program's effectiveness to meet these goals and objectives.

1974 EVALUATION PROJECTS--OFFICE OF PLANNING AND EVALUATION

Study of Demand for Post-Graduate Training to Acquire Entry-Level Job Skills: Anecdotal evidence suggests that one response to the oversupply of college graduates in some academic disciplines is for new graduates to seek more specific occupational training after graduation. Available data will be analyzed to verify whether such a trend in fact exists and to estimate the costs and enrollment impact which may result.

Advantages and Disadvantages of Student Loans for Women: Since student loans are repaid over a number of years following the completion of an educational program, loan financing of education affects an individual's life choices in many ways. Since the timing of education and other life choices are often different for women than for men, the differing patterns need to be analyzed to determine differential impacts. Existing data sources would be utilized.

Status and Resources of Independent Students: The problem of identifying the conditions under which parents should be relieved of any expectation that they will support their "independent student" offspring has plagued needs-analysis systems. The proposed project would examine different definitions of "independence" to determine the income and demographic distribution of such relief for parents. Existing data sources would be utilized.

Study of the Oversupply of College Places: Available analysis indicates that many types of colleges could easily expand the number of places for which they recruit students. If this is so, present estimates of oversupply and competition for enrollments may be understated. The project would develop alternative projection models, and specify the consequences of alternative sets of assumptions about potential for expansion, and delineate implications for Federal support under the HEA.

Feasibility Study for a Federal Census of the School Aged Handicapped: One of the major problems in providing equal educational opportunity to the school aged handicapped has been the reluctance of LEA's and SEA's to identify the population accurately, allowing neglect through oversight. As a result, most States estimate the population at 8 to 12% of all school aged children, based on limited earlier studies. Increasingly, due to litigation and changed State laws, the schools are being required to provide full educational opportunity for handicapped children.

An actual census of the handicapped would be the best way to realistically determine the needs of the population; however, such a census would be difficult to complete, from both a logistic and a legal perspective. The possible violation of a child's civil rights through labelling must be considered along with the need for standardized data and norms. The trade-offs between a Federally administered census and State-run censuses must be examined. This census would provide an equitable basis for distribution of State grants for the handicapped and identify areas with special needs due to population variance.

Enrollment Effects of Tuition Differentials: Although it is generally believed that differences in tuition charged affect enrollments, useful qualitative national estimates of the impact of such differences have not been available. The project would seek to analyze NCES longitudinal data to determine whether such estimates can be made from this data base and to specify any implications for student aid programs.

Analysis of ESEA Title I Comparability Reports: Under comparability, districts which receive Title I monies must provide Title I project schools with services at least equal to those provided to the non-project schools. This guideline is necessary to assure equal treatment of project schools and that Title I funds are not used to supplant the services a district provides under its regular program. This study is to provide summary reports of the comparability status of individual districts and of districts by State.

Handbook on Management of Evaluation Contracts: This handbook will provide guidance on successful monitoring of evaluation contracts to assure timely and professional results.

Abstracting of Evaluation Studies: Abstracting and indexing of final reports of those HEW evaluation projects not previously abstracted and indexed will be done to support a documentation center providing reference services and dissemination of evaluation studies.

Development of Improved Evaluation Methodologies: Syntheses on several path breaking or key issues in research methodology will be made to develop improved techniques for program evaluation.

Report on Ethnic Minority Women: An analysis will be made of data collected by sex on the status and problems of ethnic minority women and the delivery of HEW services to them.

ATS-F Satellite Project--A Technical Evaluation: An analysis of the technical performance of various hardware technologies related to ATS-F satellite communications experiments will be made.

User Needs--An Evaluation of their Implication for Technological Applications: This project will produce an assessment of technologically delivered instructional and information services upon the consumer, and will determine elements in the design of the man-machine interface that produce optimum benefit.

Evaluation of Family Planning Services for Teenagers: To (1) obtain data on the accessibility and provision of family planning services to persons under age 18 in a variety of delivery settings (other than offices of private physicians), but with particular emphasis on programs funded directly by HEW, to (2) analyze the information obtained for elements of good and poor service accessibility and delivery, to (3) make recommendations for improving accessibility and quality of services to the young patient in HEW-funded programs, and to (4) prepare information for dissemination to both HEW-funded and other programs about successful services for the young patient.

Evaluation of the Adequacy of "Programs of Requirement" for Health Facility Projects (Office of Administration and Management): To evaluate the adequacy of the "Programs of Requirements" in general use in development of DHEW supported health facilities; the timing of the preparation of the document; the extent of participation by users, owners and professionals; and to develop a guideline document to improve future programs of requirements.

1974 EVALUATION PROJECTS--REGIONAL AGENCIES

Review of Effectiveness of A-95 Review Process as Applied to HEW Grant Programs. The aim of this project is to determine the extent to which and manner in which State and local general purpose governments (GPGS) are able to use the A-95 process to impact the planning and delivery of HEW funded programs, to identify ways in which the impact can be enhanced, and to indicate how GPGS' involvement in the A-95 review process can be tied in with their own planning and management systems. (I)

Development of Model Interagency Strategy for EPSDT Implementation, Monitoring and Evaluation. A coordinated Work Plan for efficient and effective management of Early and Periodic Screening, Diagnosis and Treatment Services to Medicaid eligible children will be developed for Region V. A data base on the status of EPSDT implication will be developed and utilized in cost-benefit and program impact studies. (V)

Comparative Analysis of HEW and State Requirements for Sub-State Planning in Minnesota. The objectives are to develop alternative mechanisms for the allocation of HEW planning resources which will encourage, complement, and/or strengthen State planning initiatives for human services delivery systems, thereby facilitating both decentralization efforts and state interests in sub-state or community operated human services. (V)

An Evaluation of the FY 1971 Flow of Funds to the 63 counties of Colorado. This analysis will use county data to deal with questions relating HEW's outlays of Federal funds to the measurable needs of counties within a State. (VIII)

An Evaluation of Federal Human Resource Programs and their Effects on Alaska Natives. The study would examine from several perspectives the nature, extent and effectiveness of current Federal efforts in human resources areas and the implications of the Alaska Native Claim Settlement Act upon them. (X)

Washington Human Resources Demonstration Project--Phase II. This effort will continue the work of Phase I to evaluate the merits of local general purpose government efforts to structure and participate in interlocal planning for the provision of human services. (X)

An Evaluation of Selected Federal Regulations on State Human Resources "umbrella" Agencies and their Impact on the Actual Delivery of Services

The overall objective of the study is to measure the effects of certain Federal regulations impacting the organization of State governmental agencies and the actual delivery of selected human resource services. (X)

Implementation and Development of Project Rating Systems. To develop and implement project rating systems to give objective measure of the strengths and weaknesses of Local Projects, and to work with States through technical assistance in the application of these evaluation findings and encourage the development of Work Plans which reflect strategy statements, measurable objectives, and performance criteria. (VII)

Evaluation of Integrated Services Delivery Systems. To analyze the Service Delivery and Management Information Systems of a Services Integration Target of Opportunity Project to determine whether or not such systems developed by one community can be adapted for others. (VII)

State of the Region Project (Region IX). To assemble existing social data for all States in the region, by county, and prepare a data book for use in planning and assessment of DHEW programs.

Evaluate Survey and Certification of Medical Care Facilities. To analyze current State organizational arrangements, staffing, and operating procedures for survey and certification work in two States, including identification of specific actions through which such work can be carried out more effectively and efficiently in each State. A set of benchmarks will be produced for use in reviewing future State survey and certification budgets and work plans. (I)

Analysis of Partnership for Health Act Implementation. Overview analyses will be made of current programs and organization relationships under the Partnership for Health Act. Areas analyzed include: the relationships of programs funded under the Act with other related public and private programs; the roles of the Governor and local government officials in influencing programming under the Act; the effectiveness of planning and management systems and sub-systems in terms of the objectives in the Act; and, the responsiveness to the general public and to target populations of programs funded under the Act. (I)

Death by Accidents and Emergency Health Care in Wyoming: A Correlational Analyses. Utilizing existing socio-economic-demographic and health data presently contained in Region VIII's Social Indicators Project, combined with emergency health data available for the State of Wyoming, this study will attempt to answer what statistically significant relationships exist between death by accidents, motor vehicle-caused deaths, death by heart attacks, in Wyoming during FY 71 and the quantity and quality of ambulance services. (VIII)

Comparative Study of the Effect of Organizational Structure on the Operations of Comprehensive Health Planning Agencies in Regions IV and V
To determine whether there are significant differences between the operations, objectives and activities of free-standing single-purpose 314(b) Comprehensive Health Planning Agencies. The study sample will be drawn from Region IV, which has made extensive use of areawide multi-purpose agencies as (b) grantees, and from Region V, which uses primarily free-standing single-purpose agencies as (b) grantees. (V)

Evaluation of Services Provided by Home Health Agencies. Review the services provided by Home Health Agencies to minorities, with particular attention to Spanish-surnamed Americans. (IX)

Migrant Health Project Evaluation. To evaluate the management and administrative capability of migrant health projects, evaluate the technical assistance and support provided by Regional Office staff and consultants to such projects, and identify ways in which the Regional Office can improve and continuously evaluate its capacity to move migrant health projects towards administrative and management autonomy, including the capacity for self-evaluation and self-monitoring for quality assurance. (IX)

Evaluation of Regional Office Data Requirements in Cooperative Federal-State-local Health Statistics System. To determine regional data requirements that could be satisfied from national Center for Health Statistics basic core data sets and to determine additional data needs for regional program management and evaluation. (IX)

Evaluation of ICF Facilities. To provide basic information about the care provided in Intermediate Care Facilities and to assess compliance with Federal regulations. (V)

Further Analysis of Evaluation of Federal Interagency Day Care Requirements. An analysis of data relating to compliance with Federal Interagency Day Care requirements and includes preparation of reports for each of the States in Region X.

Evaluation of Consumer Participation in AoA State and Local Programs. An assessment of the degree of consumer participation on State and local AOA advisory councils. (X)

Regional Data Network (Family Planning Services Module). To improve the reliability, comparability and use of data items currently collected and to design and install a system which will consolidate existing data at the State and local levels on patients, clinic operations and utilization of fiscal procedures and impact indicators in a uniform and easy-to-read format for management and evaluation purposes. (IV)

1974 EVALUATION PROJECTS -- HEALTH

OASH

Evaluation of National Blood Policy: To measure progress toward achievement of the National Blood Policy objective.

Evaluation of Research Duplication: Toxic substances, Medicinal Products: To increase coordination and eliminate unintended duplication of research activities, using these subjects as examples.

Evaluation of Health Services Data Systems: To review the variety of current data collection activities of the health agencies as a basis for development of a more coordinated system.

Evaluation of the Effect of Grant Decentralization: To design a strategy and method for the evaluation of specific programs which have been decentralized.

Evaluation of the Priority Setting Process for Biomedical Research: To evaluate the current process for priority setting and resource allocation for biomedical research and design and test the feasibility of other approaches to this process.

Evaluation of the Federal Role in Assuring a Scientific Basis for Clinical Medical Practice: To develop a design for undertaking a review of the scientific basis of procedures in common use in clinical medical practice.

Short-Term Contractor Assistance for Evaluation: To provide assistance to the Regional Health Administrators in the development of evaluation capabilities and the conduct of brief evaluation activities.

Program Management Review System: To assess current practice and develop improved methods for the program management review system in order to aid grantees and the Regional Offices in making decisions on the management of grant programs.

Evaluation of Effectiveness of Varying Modes of Rural Health Care: To determine the effectiveness of various modes of health care in rural areas.

HSA

Technical Assistance in Development of HSA Evaluation Plan: To identify the critical issues and decisions to be addressed, and define the data required for the development of an effective evaluation plan for HSA.

Technical Assistance on Periodic Basis from National Bureau of Standards: To provide short term technical and scientific advice in the design and execution of evaluation projects.

Analysis of Grant Award Patterns: To analyze the significant characteristics of grant requests which have been approved and disapproved in order to improve the grant award process.

Analysis and Evaluation of Criteria for Selecting HSA Grantees: To determine what criteria are used in the selection of grantees and how they are being applied.

Impact of Shift from Project Grants to Formula or Revenue Sharing Grants on HSA Programs: To project the probable impact on HSA programs of a shift from project grant to formula grant or revenue sharing forms of funding.

Existing and Projected State Priorities for Use of Health-Related Formula Grants:

To review the States' procedures for setting priorities and funding health programs through formula grants and to assess the efficiency and effectiveness of their approaches.

Patterns of Community Involvement in Planning and Controlling Operations of HSA-Supported Projects: To determine the extent to which consumers are involved in planning and managing the development and operation of HSA-supported health services delivery projects.

Methodology to Assess Impact of HSA-Supported Projects and HSA Formula Grants on Health Status of Target Populations: To develop a reliable method for assessing the health status of defined populations and for measuring the impact of HSA-supported projects on health status.

Impact of Cooperative Arrangements for Child Abuse Services: To determine the procedures used for cooperative child abuse service programs and evaluate the effectiveness of these arrangements.

Services to Populations by Selected Ambulatory Care Projects: For a sample of ambulatory care projects supported by HSA, to determine the proportion of specified target population actually receiving services.

Progress Toward Third-Party Collection Targets in BCHS-Supported Projects: To determine the extent to which health service delivery projects are receiving third-party payments, to identify major obstacles and describe mechanisms for overcoming the obstacles.

Comparison of Cost of Care in Comprehensive Ambulatory Care Projects with Such Costs in Other Settings: To compare the cost of health services provided by HSA-supported ambulatory care centers with costs in conventional services arrangements.

Comparison of Cost of Care in BCHS-Supported Ambulatory Care Projects with Such Costs in Other Settings, When Costs of Grant Administration and Technical Assistance are Added: To compare the cost of health services provided by HSA-supported ambulatory care centers with costs in conventional health services arrangements when administration and technical assistance costs are included.

Health Service Scarcity: Causes and Reduction: To develop measures to determine health service scarcity and to develop a model for the evaluation of scarcity reduction programs.

Cost-Effectiveness of Medical Audit Protocol: To assess the effectiveness of the medical audit protocol in improving delivery of care, to analyze the costs of this process and to determine whether the costs can be reduced.

Methodology for Evaluating Accessibility, Comprehensiveness and Continuity of Care in Ambulatory Care Projects: To develop a standardized approach for comparing ambulatory care centers supported by HSA with other health services providers with respect to accessibility of service, comprehensiveness of service, and continuity of service.

Validation and Testing of a Clientele Perceptual Survey Questionnaire and Methodology: To review the usefulness of a survey instrument for testing the perception of clients of the services they receive as a tool in management of service programs.

Impact and Costs of Technical Assistance to Representative BCHS Grantees and Non-Grantees: To evaluate the adequacy, effectiveness, and efficiency of technical assistance provided to grantees.

Seminars for Evaluation Personnel of Selected Ambulatory Care Projects: To train administrators, project directors, and evaluation personnel in grantee agencies in the techniques of evaluating comprehensive health service delivery programs.

Services to Target Populations by Selected Family Planning Projects: For a sample of HSA-supported family planning projects, to determine the proportion of the target population actually receiving services.

Progress Toward Third-Party Collection Targets in BCHS-Supported Family Planning Projects: To determine the extent to which family planning projects supported by HSA are receiving third-party payments, to identify major obstacles and describe mechanisms to overcome these obstacles.

Comparison of Accessibility, Comprehensiveness, and Continuity of Care in Neighborhood and Family Health Centers with Such Factors in Other Settings: To determine how neighborhood and family health centers compare with conventional health services providers with respect to accessibility, comprehensiveness, and continuity of care.

Analysis of Family Health Center Reports: To provide an analysis for each center and for all centers combined of the achievements of family health center programs.

Viability of Prepayment in Family Health Centers: To determine which organizational and treatment arrangements appear to be most effective and most adaptable to HMO development.

Development and Pilot-testing of a Methodology for Evaluating HMOs: To pilot-test and refine a methodology for evaluation of HMOs.

Impact and Costs of Technical Assistance to Emerging HMOs: To evaluate the adequacy, effectiveness, and efficiency of technical assistance provided by HSA to emerging health maintenance organizations.

Comparison of Accessibility, Comprehensiveness and Continuity of Care in Maternal and Infant Care and Children and Youth Health Care Projects with Such Factors in Other Settings: To determine how maternal and infant care and children and youth health care projects compare with conventional health services providers with respect to accessibility, comprehensiveness, and continuity of care.

Analysis of Migrant Health Project Reports: To analyze the activities of migrant health projects for management aid to each project and for nationwide perspective.

Accessibility of Health Services to Migrant and Seasonal Farm Workers, and Impact of Migrant Health Projects on Accessibility: To determine what health care services are generally accessible to migrant and seasonal farm workers and the characteristics of inaccessibility.

Comparison of Comprehensiveness, Continuity, and Quality of Care in Migrant Health Projects with Such Factors in other Settings: To determine how migrant health projects compare with conventional health services providers with respect to comprehensiveness, continuity, and quality of care.

Comparison of Accessibility of Services from National Health Service Corps Assignees with Accessibility of Services from other Sources: To determine the extent to which assignment of national health service corps teams or individual personnel to medically underserved areas has had an impact on accessibility of health services in those areas.

Case Studies of Interaction Between National Health Service Corps Assignees and Host Communities and Impact on Long-term Locational Decisions of Assignees: To determine the extent to which relationships between assignees and their host communities influence current operations and the future outlook for retention of assignees in underserved areas.

Impact and Costs of Technical Assistance to National Health Service Corps Assignees and Host Communities: To evaluate the adequacy, effectiveness, and efficiency of technical assistance provided by HSA to National Health Service Corps assignees and host communities.

National PSRO Data System: To develop a plan for a national data collection capability.

Development of PSRO Evaluation Criteria: To develop a set of criteria against which to measure the performance and impact of PSROs.

Baseline Data Collection for Evaluation of PSROs: To determine the baseline data required for measuring the results of PSROs and develop a methodology for collecting such data.

Cost Impact of PSROs on Medicare and Medicaid: To determine the changes that occur in Medicare and Medicaid costs as a result of the implementation of the PSRO program and the factors that influence those changes.

Changes in Provider Behavior Due to PSROs: To determine the factors that tend to produce change in provider behavior in relation to PSRO operations and to analyze the relative effectiveness of alternative change inducing activities.

Analysis and Evaluation of Alternative Existing Mechanisms for Quality Assurance: To identify various quality assurance methods now in operation, evaluate the relative efficiency and effectiveness and their applicability to the PSRO program.

Analysis and Evaluation of the Relative Effectiveness of Alternative Forms of Health Care Standards: To identify the alternative forms of health care standards available and evaluate their relative effectiveness in assuring the quality and appropriateness of care.

Impact of Initial Technical Assistance to PSROs: To determine the technical assistance needs of PSROs, examine the types of technical assistance provided, and assess the effectiveness of the technical assistance rendered.

Survey of Existing Quality Assurance Data Sources: To identify and classify data sources that can contribute to quality assurance efforts and to continue to keep abreast of new developments regarding such data sources.

Cost and Quality Implications of the Renal Dialysis Program: To determine the cost and quality impact of this program on Medicare beneficiaries and to provide a data base for effective program management.

Evaluation of Peer Review Mechanisms in IHS: To assess and improve the system for judgement of the quality of care provided through the Indian Health Service, including the role of peer review, and to study the relationship of quality assurance in IHS with PSRO program.

Methodology for Monitoring Quality of Care in Comprehensive Ambulatory Health Care Projects: To develop a methodology for evaluating and monitoring quality of care in ambulatory health care centers.

Prototype Testing of Methodology for Monitoring Quality of Care: To determine the efficacy, flexibility, and cost of methodologies for assessing and monitoring quality of care.

Service Cost Determination: To determine the costs of each type of service provided to its beneficiaries by the Federal Health Program Service, including the PHS hospitals.

Tribal Evaluation Organizations: To focus on consumer perspectives in assessing the effectiveness of Indian health service programs and to build evaluation capabilities into the evolving program of Indian self-responsibility for community development and program operation.

Effectiveness of the California Rural Indian Health Board (CRIHB): To develop progress and cost measures for this program and to enhance the management capability of the Boards.

Evaluating a National Community Health Representative Program: To assess the operation involving community health representatives, and to develop a national reporting system to permit comprehensive analysis of this program.

An Evaluation of the Present and Potential Indian Health Service Utilization of Third-Party Payments: To determine the feasibility of increased third-party reimbursements to Indian health services such as the California Rural Indian Health Board, and to explore the possibility of alternative methods for funding IHS indirect operations.

Evaluation of Present and Potential Utilization of Available Resources: To assess the degree to which management practices and procedures maximize the efficient use of contract health service resources and to evaluate the potential utilization of alternative sources, funding, or service delivery.

Evaluation of Indian Health Service Upward and Horizontal Mobility Programs: To assess the experience of employee career development programs, the need for additional training positions, and the utilization of employees completing work under this program.

Feasibility of Program Integration in Selected Communities: To determine the feasibility and projected impact of project integration in selected communities.

Case Studies of Secondary Effects on Communities of Selected HSA Programs: To determine what secondary effects, if any, have occurred within communities as a result of establishment and operation of HSA-supported programs.

Implications of National Health Insurance on HSA Programs: To determine the components of HSA-supported programs that would be directly influenced by the proposed Comprehensive Health Insurance plan, analyze the effect of these components, and develop recommendations for reconciling issues.

Health Needs Determination: To develop a health needs profile for persons eligible for services through the Bureau of Federal Health Programs and determine the extent to which these needs are currently being met.

Secondary Benefit Determination: To develop data concerning secondary benefits derived from the operation of Federal health programs facilities, implications of these programs for the community, and potential effects of changes in the use of these facilities.

Definition of Service Delivery Alternatives: To assess the potential of alternative methods of delivering services to persons eligible for programs of the Bureau of Federal Health Programs.

BFHP Manpower Distribution and Utilization: The U.S. Coast Guard: To evaluate the criteria used in assigning personnel to the Coast Guard program.

ADAMHA

Evaluation of Persons who Complete or Drop Out from Alcohol Treatment Centers: To gain information on the success of treatment for those alcoholism clients who voluntarily terminate from the ATC treatment program; to determine the causes for such terminations; to determine their alcohol use patterns; to determine why we are able to treat some clients better than others; and to ultimately improve our capacity to retain and treat those who drop out from the program.

Follow-up Study of Patients in the TCU-DARP System: To provide accurate and current information on the impact of attending a treatment program in altering the drug habit and life style of the patient. The evaluation will, likewise, address the recidivism curve and provide data on the effect of length of time out of treatment on recidivism.

Development and Test of a Methodology for Evaluation of the Service Research Program: To develop a system for evaluating services research, with special emphasis on utilization, which can be applied to all R&D related to alcoholism, drug abuse, and mental health services. The system should assess research program planning, management, and outcome, including aggregate assessment of project success, potential user awareness of relevant research findings, and user response to program fundings in literature references and program improvements.

Development of Standards for CMHCs: To develop a set of standards by which mental health centers can be evaluated and certified; to develop procedures for: (1) assessing the efficacy of the standards in meeting these objectives; (2) applying them; (3) training surveyors in their use.

Comparison of CMHC Efficiency with that of Alternative Organized Care System: (a) To develop data on cost of treatment per hour, and cost per treatment episode for similar diagnostic categories and in similar modalities, under different settings of organized care systems such as publicly or privately-funded centers, HMOs, etc.; (b) to describe and evaluate the effectiveness of the management practices, professional incentives, allocation of time to direct patient care in the various organized care systems for delivery of mental health services.

Development of Evaluation Methodology for State Program Development: To derive a set of measurable objectives for the SPD activity, and to design and pretest a methodology to assess their achievement.

Evaluation of the Effectiveness of Alcohol Treatment Centers: To determine models of ATC treatment which appear to be more effective than others, and to discriminate among these therapies to determine which types of alcoholism clients are best served by their programs.

Evaluation of the Impact of Single State Contract on Promoting More Efficient Local Operations: To determine the number and type of patients treated under single State contracts and to compare service delivery mechanisms, administrative arrangements and costs of treatment with traditionally-funded programs. Careful attention must be given to comparing local and State overhead and administrative costs in running single State contracts with the same costs to the Government for running grant and contract programs.

Evaluation of Crime and Delinquency Center Program and Management Strategies. To reassess the objectives and present priorities of the center, to review expenditures, projects and staff efforts, to review needs in the field, and to determine the extent to which current efforts are most effectively and efficiently aimed at meeting the research needs.

Evaluation of Services Provided to Alcohol and Drug Abusers in the Same Program: To determine cost per patient and relevant measures of outcome for alcoholism and drug abuse clients treated in the same program, and to contrast these data with similar information on alcohol and drug clients in separate programs.

Evaluation of Recruitment and Training of Minority Manpower for Mental Health (1) To evaluate the effectiveness of current minority recruitment procedures in community service facilities funded under ADAMHA programs; (2) to assess the quality of training for minorities on the job, as well as their original training for the present job; (3) to stimulate minority manpower requirements in community service facilities of ADAMHA; (4) to determine the career ladder for minority employees in community service facilities funded under ADAMHA program;

(5) to determine whether innovative services for minority clients have been introduced which leads to requirements for additional minority personnel.

Evaluation of Mental Health Scientific Information Services: To determine the size and nature of the audience for NIMH scientific information, and to determine if the information is timely and useful for those requesting it.

Improvement of NIMH Evaluation System: To develop in ADAMHA a structure for evaluation, identifying the critical issues and decisions to be addressed and defining the data required for decision making and a strategy for its acquisition, realistically dividing functions between ADAMHA and its constituent institutes.

State Alcohol Program Effectiveness: To determine results of community-level programs for individuals who were treated centrally for alcoholism problems and subsequently released to community support programs.

Implementation of a Consolidated System for Evaluating and Monitoring Drug, Alcohol, and Mental Health Services: To implement and test a system to reasonably serve needs of decision makers at facility, local, State, and Federal levels, a system based on a previously developed model.

Evaluation of Preventive Education Programs in Community Mental Health Centers: (1) To evaluate the impact of educational and preventive efforts of CMHCs in their catchment areas; (2) to evaluate the impact of consultation services provided to social agencies (except schools) on their ability to deal with mental health problems of their clients; (3) to estimate the volume of such activities nationally; and (4) to describe the most successful programs in the country, and isolate factors responsible for their success.

Data Collection and Evaluation of American Indian Projects: To learn of the impact of NIAAA funded projects upon alcoholism and its side effects in the Indian population.

Data Collection and Evaluation of Public Inebriate Projects: To provide information regarding the identification of client benefits from these projects as well as information concerning management decisions relative to future funding and program changes within the total program and the individual projects.

Development of a Methodology to Better Evaluate the CMHC Program (North Carolina): To complete work on methodology initiated under contract 73-1, the methodology is designed for a comprehensive evaluation of community mental health facilities at the local level.

Implementation of the NIAAA Data Collection and Monitoring System: To obtain, process and present these data required for evaluation of alcoholism programs for projects of:

Alcoholism Treatment Centers
Public Inebriate Program
American Indian Alcoholism Program
Programs for Alcoholic Employees in Industry
Drinking Driver Program

Development of a Manpower Information System: The specific objective is to assure the availability of appropriate designs, methodological approaches, survey techniques, data collection and analysis systems on which can be based an effective and efficient mental health-manpower and training information system.

Evaluation of Specialized Drug Programs Oriented to Selected Populations: To determine the effectiveness of special orientation drug programs for their specific populations and to judge whether maintenance of such programs is efficient within the context of general drug abuse treatment programs.

Evaluation of the Efficiency and Effectiveness of CMHCs Functioning Within HMOs and other Comprehensive Health Care Settings: To determine the costs of mental health services participating in HMOs, and other comprehensive health care settings, to measure accessibility to and acceptability of services, to evaluate the effectiveness of mental health professionals in enhancing the ability of the general health care professionals to deal with psychological problems in their clients and to assess confidentiality of psychiatric problems in health care settings.

The Process of Program Decision Making: To analyze an important governmental decision in the public health area from the vantage point of the individual ultimately responsible for making the decision; in particular, to identify the various types of information that were used, as well as the types of information that were needed but were unavailable.

HRA

Development of a Strategy, Plan, and Documented Procedures for Over-all Evaluation of the Cooperative Federal-State-Local Health Statistics System: To develop a strategy and a plan of procedures for evaluating the effectiveness and efficiency of the system.

Evaluation of Alternative Methodologies for Medical Care Costs, Expenditures and Charges Surveys: To determine the specific data needs, the size of sample to meet these needs, and the logistics required for an effective survey.

Fixed Examination Centers as an Alternative to Mobile Examination Centers in the Health and Nutrition Examination Survey: To determine whether the use of fixed examination centers could provide comparable data meeting acceptable standards, would increase cooperation, would increase information secured by overcoming problems of equipment failure, and how costs would be affected.

Evaluation Study to Improve the Quality of National Morality Statistics on Causes of Death: To assess the factors that influence the quality of reporting and to develop recommendations for improvement in medical certification practice.

Evaluation of Comparability of U.S. and Other National Infant Mortality Rates: To evaluate the degree of conformity of reporting practice with World Health Organization definitions.

Pilot Study for a National Completeness of Death Registration Test: To verify the assumption that death registration in the U.S. is virtually complete.

Evaluation of the Emergency Medical Services Demonstration Projects: To coordinate the assessment activities in each specific project in an effort to identify factors within an emergency medical services system that influence patient outcome.

Evaluation of the Experimental Medical Care Review Organization (EMCRO) Program: To assess the performance of the program in relation to the specific objectives established for each grant.

Implication for Institutional Staffing of Possible Reductions in Availability of Foreign Medical Graduates: To assess the role of foreign medical graduates in hospitals and other institutions, and the extent to which care delivery processes have been structured around anticipation of increasing supplies of such manpower.

Evaluation of Family Medicine Grants to Hospitals: To design an evaluation procedure to secure early feedback on program characteristics, progress and effectiveness in order to influence program actions.

Data Collection System for Student Assistance: To develop a comprehensive data system that will facilitate the evaluation of experience in student assistance, including examination by professional fields and probable and actual career decisions.

Longitudinal study of Impact of Nurse Practitioners on Delivery of Health Care: To analyze the changes which occur in community health needs and utilization of health resources in areas where nurse practitioner services are initiated.

Methodology for Assessing Degree to Which Team-Trained Dentists Practice Team Dentistry: To assess the extent to which team trained dentists are establishing team practices, are implementing team concepts in their practices, and to identify factors which constrain dentists from operating team dental practice.

Evaluation of Accessibility of Health Care Facilities by Methods of Transport of Both Patients and Material: To determine the operational capabilities and the degree of effectiveness of varied public and private transportation systems for emergency patients.

Evaluation of the Hill-Burton Method of Determining Longterm Care Bed Need: To assess the adequacy of current methods for determining needs for long term care beds and to compare it with planning for acute care beds.

Evaluation of the Role of HRA Programs in the Diffusion of Innovations in the Delivery of Health Services: To analyze the role of HRA programs in the diffusion of innovation in health delivery systems, including questions of effective change agents, communications methods, and conditions for acceptance of the innovation.

Evaluation of Methods of Determining Health Services Scarcity and Surplus Areas: To examine the data and criteria currently used to classify scarcity areas, to analyze their reliability, consistency and acceptance, and to consider alternative approaches.

Evaluation of the Impact of HRS Programs on Regionalization of Health Care Delivery: To explore the impact which HRA programs have on the regionalization of health delivery systems including question of efficiency.

Evaluation of Health Professions Careers Programs for Non-White Minorities and Low-Income Individuals: To examine the strategies which were utilized in conducting these programs, to review the criteria and procedures employed in awarding grants and contracts, and to identify needs for improved management of the program.

Follow-up to 1972 Inventory of Registered Nurses Study: To analyze data on the initial preparation of the registered nurse population and the highest degrees held, and to explore alternative approaches to present support mechanisms for the provision of effective nursing care.

Evaluate State Mechanisms and Linkages between Health Manpower Planning and the Allocation of Financial Resources for Health Manpower Education: To determine the effectiveness of the program as it has been initiated by HEW in three States and of similar programs in those States where they have been initiated independently.

National AHEC Program Evaluation: To capture the results of the first year's experience of the national program.

Evaluation of the Utilization of Nursing Personnel: To evaluate the productivity of nursing personnel in the institutional and ambulatory care settings.

Assessment of Dental EFA Training Programs: To categorize Federally-supported EFA training programs according to selected educational characteristics and to assess the relative effectiveness of various educational approaches by examining to what extent graduate EFA's are being employed in dental practices and how they are being utilized.

Methodology for Annual Team Program Assessment: To develop a methodology for an annual assessment of the quality and cost-effectiveness of individual TEAM training programs, taking into account both the specific educational experiences provided students for the achievement of each of the four goals specified in the TEAM guidelines and measures employed to evaluate student achievement.

Evaluate the Effects of Shortened Programs of Medical Education Upon both Enrolled Students and Sponsoring Institutions (3 phases): To determine the effectiveness--both curricular and economic--of DHEW sponsored programs for the shortening of traditional medical school programs.

Evaluation of Hill-Burton Plant Evaluation System: To determine the degree of effectiveness of the physical plant evaluation system as applied by the various States in fulfilling its role as a method to establish need and priorities for modernization projects.

Evaluation of Hill-Burton Methods of Determining Outpatient Facility Needs: To study the current mechanism for planning outpatient facilities to find out if present methods are adequate for determining need.

Evaluation of Existing Materials Management Systems: To evaluate the cost benefits of those systems which are presently in operation for proper guidance to future projects.

Program Design and Evaluation Framework for Health Career Opportunity Grants: To define independent targets and measurement indicators for individual grants and for the national program; and to develop a mechanism for introducing evaluation feedback into the program design process.

Evaluation of Dissemination of Information from HRA Program Activities: To analyze the processes by which health information is disseminated by the various units of HRA, identify users and non-users of the information, determine the acceptability of the information provided, and to consider methods for implementing successful practices observed.

Evaluation of the Effectiveness and Efficiency of the Section 1122 Review Process: To evaluate the effectiveness and the efficiency of the process utilized in reviewing health care construction regulated by this section.

Evaluation of the Effectiveness of the CHPS Agency Assessment Program, Performance Standards, and Technical Assistance Activities in Strengthening CHP State and Areawide Agency Performance: To evaluate the impact of CHPS program efforts at improving agency performance and to strengthen the planning abilities of this system.

Evaluation of Current and Proposed State Laws and Regulations Dealing with Confidentiality of Data: To assess the experience under current state laws dealing with confidentiality of data and to lead to the development of effective model state laws.

Evaluation of Statewide Hospital Discharge Abstract Systems: To analyze the characteristics of effective processing and utilization of the abstract system and to perform a cost benefit analysis on the major organizational and functional arrangements.

Design and Conduct of Meetings and Workshops to Evaluate the Development of the CHSS: To involve participants, producers and consumers of health data as a part of the system in the process of evaluating the procedures, costs and progress of the system.

Comparison of Several Geographic Coding Techniques: To evaluate the types and degree of conformity of coding practices for geographic place of an occurence of particular events in light of the effect this project has on the distribution and use of resources at lowest geographic levels.

Methods and Procedures for Maintenance of Data Quality Within CHSS: To describe, evaluate, and make recommendations regarding quality control systems in operation at various state, local, and federal levels regarding the system.

Evaluation of a Prototype of a National Ambulatory Medical Survey: To provide data on ambulatory medical care that will be used for evaluation of delivery of medical services and to provide a model.

Evaluation of Communication Efforts and Needs Within the Cooperative Health Statistics System: To determine the effectiveness of communications in the operation of the system and design more effective methods as needed.

Evaluation of Alternative Methods for Classification and Coding of Morbidity and Surgical Procedures: To determine the use being made of currently available statistics using present classification procedures, the results that would be obtained when two or more classifications systems are applied to the same raw data, and the data needs by various organizations which use different classification schemes.

Evaluation of Computer Software Needs for CHSS Data Processing: To describe systems currently in use and systems needed to produce adequate results keeping in mind ease of use adaptability to various sizes and types of equipment and accuracy of results.

Evaluation of Impact of HRA Programs on State Departments of Human Resources: To describe and analyze the relationships between health programs sponsored by HRA and other health programs of concern to State Departments of Human Resources, and to assess the impact on planning and services integration among health and other human services programs.

Evaluation of Current Practices and Methods in the Utilization of Data: To evaluate methods of analysis and sources of data which would be most useful in program management and decision making and to identify innovative uses of data toward the ends.

Develop Methodology for Conducting Vital Records Followback Surveys and Expand the Scope of these Data in Health and Demographic Areas: To develop a methodology and compile data needed for evaluating the quality of vital records data developed in the states.

FDA

Measure-Act-Measure: Regulatory Letter: To measure the effectiveness and efficiency of the regulatory letter in bringing about compliance and to compare this with other regulatory actions.

FDA Manpower Utilization Program for FY 74: To apply the results of earlier manpower utilization studies to the agency's field activities and radiological health program and assess the results.

Cosmetic Experience Project: To develop data on cosmetic use, obtain indepth injury diagnoses in a clinical setting, and learn of consumers own perceptions about cosmetic risks.

Validation and Extension of Compliance Model: To validate the model previously developed using more recent inspection data and results of field tests, to test the sensitivity of the model and review the model logic.

Cost/Benefit Study of Antibiotic Certification: To compute the costs and quantify the benefits of antibiotic certification and compare these costs and benefits with alternatives.

Neighborhood Youth Project: To determine the feasibility of an FDA-Youth Group Cooperative Program and to test the effectiveness of youth groups in designing and conducting consumer information projects in their neighborhoods.

CDC

Effectiveness Criteria in Venereal Disease Control Programs: To establish additional criteria that can be used to measure the effectiveness of the Venereal Disease Control Program.

Extent and Characteristics of Venereal Disease Education in School System: To examine the extent and characteristics of venereal disease education programs currently provided in the nation's school systems.

Effectiveness of Proficiency Testing in Cytology in Relation to Early Detection of Uterine Cancer: To evaluate the effectiveness of laboratory proficiency testing methods in cervical cytology and evaluate the benefits of routine pap tests periodically.

Toxic Substances List Evaluation: To evaluate the usefulness to its users of the annual list of toxic substances and consider alternative methods of presentation and types of data.

Validation of Data Used in Evaluating National Immunization Status: To compare the current national immunization survey with alternative data sets for determining the effectiveness of the National Immunization Program.

Evaluation of Alternative Methods of Delivering Venereal Disease Education: To evaluate alternative methods of delivering VD education in a representative sample of school districts.

The Effect of Discontinuing Project Grants for Tuberculosis (Categorical): To determine the effect which national funding patterns have had on tuberculosis control activities including availability and accessibility of outpatient clinics, locating contacts, providing preventive treatment of close contacts and other procedures.

Training Grant Program Evaluation: To secure information and analyze the results on the training grant program of NIOSH, the type of students trained, their positions after graduation and their further education.

Methodology Development: To examine the results of the current methods of dissemination of CDC laboratory diagnostic results and evaluate the utilization of these results.

Information Dissemination Strategy: To consider alternative strategies and develop a model of an effective strategy for dissemination of information by NIOSH including questions of appropriate audiences, frequency of dissemination, methods of dissemination, etc.

Evaluation of Environmental Health Services Delivered by State and Local Programs: To evaluate the environmental health services at state and local levels including consideration of changes and functions by health departments, gaps that exist in delivery of environmental health services and the HEW role in these programs.

NIH

Longitudinal Study-Freshmen Cohorts: Evaluate change in the numbers and proportions of students who: (a) choose biological sciences as their career field, (b) indicate teaching and research in the biological sciences as their primary career activity, (c) enter graduate study immediately after receipt of the baccalaureate or postponed entrance to graduate study, (d) plan to enroll in graduate study in the biological sciences.

NSF Graduate Enrollment and Support: To assess trends in graduate enrollment in selected science fields most relevant to NIH missions. This survey will permit evalution of the impact of Federal policy on graduate student support and first year graduate enrollment in the sciences.

NRC Career Patterns: To assess how NIH training support has affected the career patterns of biomedical scientists, the flow of talent into the bio-sciences, and contributions to health care delivery.

1970 Baseline Grant Manpower: Completion of the 1970 NIH research grants manpower survey to provide base data for future findings.

Annual Grant Manpower: Utilization of the 1970 NIH research grants manpower survey to assess the impact of NIH's research grants on utilization of biomedical research manpower and to identify NIH's share of the biomedical research labor force.

Sampling Surveys-Grant Manpower: Periodic sampling surveys to round out information from the 1970 NIH research grants manpower survey.

Earned Doctorate Survey: To evaluate trends in (1) PHD output in specific fields and disciplines of interest to NIH, (2) numbers of Ph.D's in these disciplines receiving Federal support, (3) production of biomedical science doctorates, (4) proportion planning post doctoral training, (5) post doctoral employment by type of employment and primary work activity.

Employment of Doctoral Scientists: Sample surveys of doctoral scientists and engineers addressing issues of concern to NIH, including: employment/unemployment status of doctoral scientists and engineers, type of work activity, employing organization, current scientific specialty, and engagement in federally supported work by agency.

Biomedical Scientist Employment Market: An analysis of market data on hiring of biomedical scientists and creation of a demand index to chronicle the pressure of demand for biomedical scientists.

Economic Rate of Return: To ascertain the past in prospective economic rates of return to those training in the biosciences and to determine if NIH can rely upon market incentives to attract a sufficient supply of capable bioscientists as required by national needs for teaching and research.

Program Project in Center Grants: To determine how long term, complex center grants affect institutions and to investigate management problems related to such grants.

Institutional Impact Case Study: To identify and define interrelationships between changes in federal biomedical research support levels, mechanisms, programmatic structures, and institutional changes in policy and planning, programs, faculty staff structures, and student admissions policies.

Econometric Similation Model: To anticipate the impact of NIH funding changes to grant and contract mechanisms, an econometric simulation model is being developed that will permit estimates to be made at any time during the fiscal year in amounts likely to be awarded to specific institutions during the current and following fiscal years.

Unfunded Research Grants: To investigate the consequences for scientific investigators that follow from not receiving an award, including whether alternative funding was found, and, if not, was the project abandoned; what differences exist between the group of investgators who received awards and the group who did not; and whether the lack of support for the project affected others, such as students expecting to obtain theses from the work of the project.

Impact Model Development--To perform longitudinal analysis of linkages among 1) patterns of biomedical research funding, 2) graduate education in the biomedical sciences, 3) the deployment and career patterns of biomedical scientists and 4) the volume and quality of scientific output in various biomedical science sectors.

Citations Study--To assess the feasibility of using publications and citations measures to provide indicators of change in productivity in health related research by 1) establishing patterms of individual journal cross cutting within the major biomedical disciplines, 2) developing models depicting the publication profiles of major NIH grantee institutions; 3) relating the distribution and citations to patterns of research funding.

National Expenditure for Biomedical Research: To ascertain the implications of distribution of social and economic costs of disease and health problems for the allocation of biomedical, and specifically NIH, research dollars.

Social and Economic Cost of Illness: To determine the social and economic cost of illness and health problems to the American people in recent years by categories of disease, using morbidity and disability data.

Social Benefits of Biomedical Research: To develop adequate methodologies for evaluating the social benefits that have accrued from biomedical research and for forecasting the potential social benefits of current biomedical research programs.

Economic Gains of Reduced Disease: To establish facts about the economic gains from reducing the incidence of acute conditions affecting groups in the population under 40 years by seeking to sort out partial elements of the gains, distinguishing health innovations stemming from biomedical research from other causes.

Research Grants Spending Patterns: To produce and analyze annual records for a period of years which will show trends in the composition of research cost actually incurred by investigators receiving research grants for NIH.

Price Deflator for Biomedical Research: To develop a suitable price deflator specific to biomedical research cost.

Biomedical Research in the U. S. and Other Countries: To assess the U. S. biomedical research performance against that of other countries using such indexes as the location of significant innovations since World War II, mandatory receipts from patents, licenses and know-how, performance in trade, patents taken out, nobel prizes, scientific abstracts, along with the characteristics of technological innovation.

International Reporting of National Health Research: To develop a continuing activity for collecting and presenting information about the health research programs in different countries, to facilitate comparison of trends of U.S. national biomedical medical research expenditres with those of other countries.

In-house Training Program: A series of monthly seminars will be established through which NIH staff will be introduced to techniques for systematic evaluation planning, methods of approaching evaluation questions, and problems in conceptualizing and quantifying complex judgment questions.

Summary and Critique of Available Data on Prevalence in Economic and Social Cost of Visual Disorders and Disabilities: To analyze and criticize all published and available unpublished studies relating to the prevalence and economic cost of eye disease disability in the United States, indicating strengths and weaknesses of existing data, and integrating all information into one well-documented report that gives consistent and accurate information that is a synthesis of the best available data.

Follow Up Evaluation of Prior NEI Supported Trainees: To survey and review records on all NINDB/NEI supported trainees since beginning of the program in 1953, and to determine the degree to which training programs have been successful in producing full-time academic research scientists and/or faculty individual sciences.

Potential Health Effects of Environmental Factors: To assess the status, implications, and competing need for research on the potential health effects of environmental physical factors.

Evaluation of Mount Sinai CATV Health Care Information Program for the Elderly: To evaluate the efficiency and cost effectiveness of an interactive CATV system to bring health care information to an elderly population for the purpose of fostering self-help and improving the health status of that population.

Use of Communications Technology to Support Continuing Medical Education: To identify needs for educational programs and materials, as well as means to evaluate the effectiveness, the manner of use of educational services which utilize communication technology, and to provide practicing physicians with practice oriented, problem oriented educational materials and to institute programs for development, testing, maintenance, and distribution of effective educational materials.

Evaluation of the Impact of On-Line Information (MEDLINE) in Health Care: To assess the frequency of transfer to primary physicians of information dealing with patient care problems and to review hospital statistics to determine whether length of stay, morbidity or mortality has been affected by the on-line information service.

Integration of TV and Data Communications: To analyze the advantages and limitations of various techniques which combine digital data in video signals in the delivery of information for health services and education.

Evaluation of K-B and Satellite Communications Systems: To provide a Telecommunications system design which would be economically acceptable for the health community and technically compatible with K-Band channels authorized by the United Nations Telecommunications Committee.

Evaluation of Information Retrieval of Current Systems in Toxicology: To assess the quantity of biomedical research papers presented at national scientific meetings which are not published as full papers and to determine if significant studies are lost from the permanent scientific record.

Diffusion Studies: To examine possible theoretical frameworks for studying the problems of diffusion of medical technologies, including learning more of the process by which innovation stemming from biomedical research has spread into general use.

Evaluation of Changes in Support of NIH Post Doctoral Research Training for MD's: To examine the manner in which the institutions and individuals have adjusted to the changes in NIH support of training to produce clinical investigators. Information will be gathered as to the number of individuals in the training status, tye type, content and expected duration of the training, and the source of support.

Mental Retardation Centers Evaluation: To evaluate the impact of the mental retardation centers on MR research and to conduct field surveys of the MR centers research by which the overall effectiveness of the centers can be measured.

Manpower Evaluation Study--Dental Research: To describe the present requirements and status of dental research manpower in teaching and research; to describe the demographic and scientific characteristics of dental teacher/

investigators; and to describe the manpower needs in this area in the next decade and recommend appropriate goals and priorities relative to dental research manpower.

Analysis of TIP Data Banks: To evaluate the content of the toxicology data bank for accuracy and completeness to measure its effectiveness in delivering needed information to the user.

Review, Evaluation, and Updating of the National Heart, Blood Vessel, Lung and Blood Program: To assess the current state of Art in the 39 problem areas of the national programs; to identify new opportunities in approaches present and future applications; to survey ongoing related programs in Federal and non-Federal organizations; and to evaluate the national needs and to modify, when necessary, the planning and direction of the national program.

Social Impact Analysis of NHLI Programs: To critically review available methodologies and to design, implement, and to analyze techniques for quantifying the social impact of medical research programs and to present recommendations on an evaluation framework to judge the social impact of institute programs.

NHLI Evaluation Basic Ordering Agreement: To assist staff in tasks which are specific, specialized in nature, and of relatively short duration, including development of NHLI devaluation strategies and planning, development of analysis and evaluation methods, evaluation and analysis of programmatic activities, and supportive activities for post-evaluation followup.

NHLI Evaluation Planning Project: To develop a systematic and coherent multi-year NHLI evaluation strategy providing a framework of priorities and directions for evaluation activities over the next several years and to develop a preliminary evaluation plan for NHLI evaluation activities during FY 1975 that will be carefully integrated with past, current and future efforts.

Management Effectiveness of Administrative Aspects of Large Scale Clinical Trials: To examine and assess the managerial effectiveness of current administrative arrangements and feasible alternatives for large clinical trials of procedures. Specifically included will be the organization, delegation of responsibility, and supervisory relationships with respect to efficiency and use of clinical trial staff.

Evaluation of the Economic and Social Implications of Coronary Artery Surgery: To (a) determine the cost and benefits of coronary artery surgery including the training of manpower and the development of facilities needed to respond to increased demands and (b) to determine the adequacy of current funding and regulatory processes particularly at the Federal level, with regard to introduction into use and dispersion of new surgical techniques such as coronary artery surgery.

Resource Availability of Behavioral Scientist and Social Psychologists for CV Research: To clarify behavioral and socio-environmental factors and their role in the pathogenesis of both cardivascular and pulmonary disease by documentation of the resource availability of behavioral scientists and social psychologists who might contribute to appropriate research in the behavioral aspects of these diseases.

Task Force on Immunology and Disease: To judge what research findings and techniques are ready to be applied in clinical practice in the manner of implementation most likely to result in health benefits; to identify special areas of research opportunity which relate to immunologic disease; and to outline, in perspective, unresolved problems and unmet health needs with recommendations as to their solution and priority order.

Determination of Meaningful Measurements of the Infectious and Allergic Disease Impact on Health and the Quality of Life: To determine the different types of data needed to measure the importance of NIAID mission related diseases, and to ascertain which of these data are readily available or those not now available. A tentative plan will be developed for obtaining the needed data not now available.

Evaluate Current Research Support and Develop a Mechanism to Determine the Proportion of Service and Research Projects Needed for an Effective Research Program: To analyze the research program supported by NIAID and its need for research services, procedure will be developed for use by the Institute in the evaluation of programs and determination of the need for research activity.

Evaluate Current Techniques, Facilities and Personnel to Meet Current and Future U. S. Needs for Diagnostic Testing Related to Viral Infections: To estimate the national need for laboratory diagnostic abilities and facilities. This information will be evaluated in terms of the research, developmental studies, training and other activities, at Federal, state and local levels, and in the private sector, needed to develop optimal diagnostic capabilities for clinical virology.

Evaluation of Research Needs in Digestive Diseases: To determine the status of current knowledge, primary problems, obstacles to research progress and future research objectives in all or selective areas of digestive diseases; to identify key research needs and opportunities, directions and plans for future development, and to determine priorities within needed research; and to determine the amount of research activities in digestive diseases being supported by government, industry, and academic institutions.

Workshops and Symposia Sponsored by NIGMS Program area: To a) assess the state of the art for ongoing programs and identify progress, needs and scientific program opportunities and b) for areas comprising important contemporary issues, annual workshops will build up the conceptual basis for possible action for program implementation.

Evaluation of the Use of Survey Methods for the Brain Tumor and Stroke Program: To evaluate methods for obtaining estimates of the incidence and prevalence of primary brain tumors and stroke, measures of the precision of these estimates and to assist the feasibility of obtaining trend data on primary brain tumors.

Manpower Resources and Needs in Otolaryngology--Research, Training, Patient's Services: To provide for the collection and processing of data from surveys focusing on manpower information in the areas of the NINDS research program, such as the number of individuals already trained and the additional number needed, the rate of attrition, the number who might expect to return to the field on a full-time or a part-time basis, and the number needed to carry out necessary research and training.

Health Sciences Advancement Award Program Evaluation: To determine the impact of the program and the biomedical research capability of the grantee institutions and to assess the validity of the program goals.

National Library of Medicine Evaluation of User Utilization of Audio Visual Program and Services: To determine of those films and video tapes order how many are used, to what purpose they are used, and for what educational objectives they are used.

Resource Improvement Grant Evaluation: To determine the catalytic effect of research improvement grants relative to increased institutional support, and the effect on regional medical library services.

Evaluation of ATS-F Health Experiments: To gather and analyze data conserving the provision of services to health, education and health care delivery via satellite and to make recommendations concerning the effectiveness, and efficiency of this program as compared to the use of alternative communication modes.

Evaluation of New Hampshire/Vermont Medical Interactive TV Network. To develop an evaluation design, establish data requirements, and gather and analyze data to provide an ongoing evaluation tool for local project managers, and to enable assessment to an impact of present program efforts.

Evaluation of the Effectiveness of Satellite Voice Communication: To assess the need for a narrow band health satellite which would provide low cost interim communications for isolated regions of the United States and its Territories.

CAI Network Evaluation: To assess the effectiveness, technical adequacy, and financial reasonableness of the CAI system, and experimental computer assisted instruction network which connects university based data centers to a multitude of operational and trial uses in medical schools and hospitals.

Evaluation of Research Needs in Nephrology and Urology: To assess the State of the art and delineate the needs in research in the fields of nephrology and urology and to devise methods to set priorities of approach to different recommended areas for use in determining research projects.

An Evaluation of Research Needs in Nutrition: To determine the status of current knowledge, primary problems, obstacles to research progress and future research objectives in areas of nutrition; to identify key research needs and opportunities and priorities for future research; and to asses the amounts of research activities in areas of nutrition and to determine whether redirection of that activity is necessary.

Evaluation of Research Needs in Diabetes: To assess the State of the art in research in diabetes; to delineate the needs for future research, both basic and applied clinical research in diabetes; to evaluate the feasibility of carrying out the research considered significant; and to set priorities of the different recommended areas of need brought out by the evaluation.

Population Behavioral Sciences Evaluation: To assess the quality of the NICHD population behavioral sciences research program and to determine an appropriate balance of funding mechanisms for this program, particularly the proper role of contracts in developing and sustaining such a program.

Scientific Assessments: To assess program development, program balance in the allocation of funds based on "State of the Art" knowledge of categorical areas within NIDR.

Information Transfer Among Dental Scientists: To improve information transfer and shorten the time between scientific discovery and application by assessing how dental investigators communicate with each other and to their peripheral associates.

Diffusion Studies: To examine possible theoretical frameworks for studying the problems of diffusion of medical technologies, including learning more of the process by which innovation stemming from biomedical research has spread into general use.

Evaluation of Changes in Support of NIH Post Doctoral Research Training for MD's: To examine the manner in which the institutions and individuals have adjusted to the change in NIH support of training to produce clinical investigators. Information will be gathered as to the number of individuals in the training status, the type, content and expected duration of the training, and the source of support.

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Analysis of TIP/Data Banks: To evaluate the content of the toxicology data bank for accuracy and completeness to measure its effectiveness in delivering needed information to the user.

Mr. **Flood**. Mr. Michel.

Mr. **Michel**. Thank you Mr. Chairman.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ORGANIZATION CHART

Mr. Secretary, as we begin, could we have for the record an organizational chart of the Department, including the names of the people in the positions they hold?

Secretary **Weinberger**. Surely.

[The information follows:]

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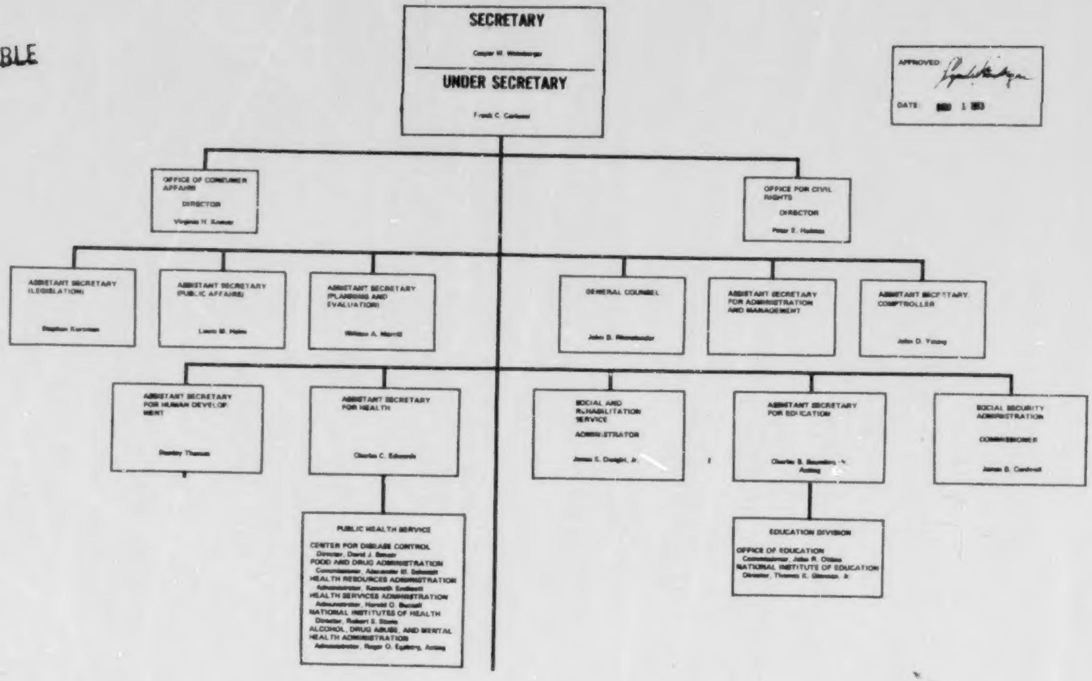
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE


SECRETARY
Caspar W. Weinberger
UNDER SECRETARY
Frank C. Carlucci
APPROVED
DATE [illegible] 1 [illegible]
OFFICE OF CONSUMER AFFAIRS
DIRECTOR
Virginia H. Knauer
OFFICE FOR CIVIL RIGHTS
DIRECTOR
Peter E. Holmes
ASSISTANT SECRETARY (LEGISLATION)
Stephen Kurzman
ASSISTANT SECRETARY (PUBLIC AFFAIRS)
Lewis M. Helm
ASSISTANT SECRETARY (PLANNING AND EVALUATION)
William A. Morrill
GENERAL COUNSEL
John B. Rhinelander
ASSISTANT SECRETARY FOR ADMINISTRATION AND MANAGEMENT
ASSISTANT SECRETARY, COMPTROLLER
John D. Young
ASSISTANT SECRETARY FOR HUMAN DEVELOPMENT
Stanley Thomas
ASSISTANT SECRETARY FOR HEALTH
Charles C. Edwards
SOCIAL AND REHABILITATION SERVICE
ADMINISTRATOR
James S. Dwight, Jr.
ASSISTANT SECRETARY FOR EDUCATION
Charles B. Saunders, Jr. Acting
SOCIAL SECURITY ADMINISTRATION
COMMISSIONER
James B. Cardwell
PUBLIC HEALTH SERVICE
CENTER FOR DISEASE CONTROL
Director, David J. Sencer
FOOD AND DRUG ADMINISTRATION
Commissioner, Alexander M. Schmidt
HEALTH RESOURCES ADMINISTRATION
Administrator, Kenneth Endicott
HEALTH SERVICES ADMINISTRATION
Administrator, Harold O. Buzzell
NATIONAL INSTITUTES OF HEALTH
Director, Robert S. Stone
ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION
Administrator, Roger O. Egeberg, Acting
EDUCATION DIVISION
OFFICE OF EDUCATION
Commissioner, John R. Ottina
NATIONAL INSTITUTE OF EDUCATION
Director, Thomas K. Glennan, Jr.

REORGANIZATIONS

Mr. **Michel**. Then also could we have some explanation for the record of the reorganizations that have occurred since you were last before us?

Secretary **Weinberger**. Yes.

[The information follows:]

DHEW Reorganization—January 1973-March 1974

During the period January 1973 through the present, six major organizational changes took place within the Department. These reorganizations involved the following:

1. Public Health Service.
2. Office of Human Development.
3. Office of the Assistant Secretary for Administration and Management.
4. Bureau of Medical Devices and Diagnostic Products, Food and Drug Administration.
5. Office of Education.
6. Bureau of Hearings and Appeals, Social Security Administration.

A description of each of these reorganizations follows. There were approximately 20 other changes of minor significance.

Office of Human Development, OS

The Office of Human Development, under an Assistant Secretary for Human Development, was established by direction of the Secretary on April 1, 1973. The Assistant Secretary for Human Development serves as the principal adviser to the Secretary on matters dealing with special populations served by the Department, including the aging, children, youth, Indians, the mentally retarded, and those living in rural areas. The Office of Human Development pulls together the following organizations from the Office of the Assistant Secretary for Community and Field Services (which was disestablished), the Office of the Assistant Secretary for Administration and Management, and the Social and Rehabilitation Service:

(1) Office of Mental Retardation Coordination (from OASCFS).
(2) President's Committee on Mental Retardation (from OASCFS).
(3) President's Council on Physical Fitness and Sports (from OASAM).
(4) Office of Child Development (from OASAM).
(5) Office of Youth Development (from SRS and OASCFS).
(6) Administration on Aging (from SRS).

Two additional components, the Office of Rural Development and the Office of the Handicapped, are new. The Office of Human Development is presently part of the Office of the Secretary.

Office of the Assistant Secretary for Administration and Management

A reorganization of the Office of the Assistant Secretary for Administration and Management took place during the period April–July 1973. The OASAM was strengthened through a rearrangement of functions and the addition of the grants management function, central payroll operations, and ADP services, which were transferred from the Office of the Assistant Secretary, Comptroller. The grants function was combined with the related function of contract management in a new Office of Grants and Procurement Management. Property management functions were combined with facilities engineering and construction functions in an Office of Facilities Engineering and Property Management. The managerial capabilities of the Assistant Secretary were enhanced through the creation of a post of overall Deputy Assistant Secretary.

Office of Education

In accordance with the requirements of the education amendments of 1972 (Public Law 92–318), a major reorganization of the Office of Education was completed in November 1973. Significant changes include the abolishment of the Office of the Deputy Commissioner for Development, creation of an Office of

Management and an Office of Planning, and the establishment of a Division of Basic Grants to administer the basic educational opportunity grant program. The drug abuse program, environmental education program, educational technology program, and responsibility for title III of the Elementary and Secondary Education Act were transferred to the Bureau of School Systems. The post of Deputy Commissioner of Indian Education was created to administer contracts and grants with local educational agencies to meet the special needs of Indians.

In addition, a request was sent to the Secretary of Health, Education, and Welfare by the Assistant Secretary for Education, on March 20, to establish a Bureau of the Handicapped within the Office of Education to be headed by a Deputy Commissioner.

Public Health Service

Effective July 1, 1973, the Public Health Service was reorganized. The Health Services and Mental Health Administration was abolished. In its place, three new agencies were established: the Center for Disease Control (formerly a HSMHA bureau), the Health Resources Administration, and the Health Services Administration. CDC was given responsibility for the National Institute for Occupational Safety and Health, but was otherwise unchanged. HRA was given health services data gathering and surveillance activities, and health service demonstration programs; the Bureau of Health Manpower Education was transferred to HRA from the National Institutes of Health. HSA was given responsibility for health service grants and direct delivery programs. The remaining two health agencies—the Food and Drug Administration and NIH—were left unchanged except for the transfer of BHME from NIH to HRA. The main purpose of the reorganization was to sharpen the Department's focus on biomedical research, health services delivery, health resources development, and consumer protection and to strengthen the role of the Assistant Secretary for Health as line manager of the health agencies by giving him the necessary personnel resources.

A further reorganization took place on September 25, 1973, with the creation of a sixth health agency—the Alcohol, Drug Abuse, and Mental Health Administration. ADAMHA consists of the National Institute on Alcohol Abuse and Alcoholism, the National Institute on Drug Abuse, and the National Institute of Mental Health, all of which were formerly part of HSMHA. NIMH was briefly under NIH from July until September 1973.

Bureau of Medical Devices and Diagnostic Products, FDA

The new Bureau of Medical Devices and Diagnostic Products was established within the Food and Drug Administration on February 7, 1974. The new bureau represents the Department's response to pending legislation regarding the safety, efficacy, and labeling of medical devices and *in vitro* diagnostic products. The bureau will conduct research, develop and apply standards, and coordinate FDA surveillance and compliance programs for medical devices and diagnostic products.

Bureau of Hearings and Appeals, SSA

The Bureau of Hearings and Appeals in the Social Security Administration is currently being reorganized and expanded in order to enable it to cope with the increased hearings and appeals workload created by the implementation of the supplemental security income program. The reorganization includes the establishment of a position of Chief Administrative Law Judge to strengthen central office direction of the regional and field hearings organization.

LEGISLATIVE PROPOSALS

Mr. Michel. In your statement you mention several legislative proposals relating to HEW that have been recommended by the administration. Would you list and summarize your legislative proposals that are currently pending before the Congress or have been announced and are ready to be introduced as bills?

[The information follows:]

ADMINISTRATION BILLS INTRODUCED IN THE 93D CONGRESS

Subject	Bill No.	Date
Health:		
1. HMO	S. 972 H.R. 4871	Feb. 22, 1973 Feb. 27, 1973
2. Food labeling	S. 1451 H.R. 5642	Apr. 3, 1973 Mar. 14, 1973
3. Medical devices	S. 1446 H.R. 6073	Apr. 3, 1973 Mar. 22, 1973
4. Medical libraries	S. 1450 H.R. 6387	Apr. 3, 1973 Apr. 4, 1973
5. National health surveys	S. 1515 H.R. 6586	Apr. 10, 1973 Apr. 4, 1973
6. Drug Abuse Office and Treatment Act (special project grants and contracts)	S. 1634 H.R. 6587	Apr. 18, 1973 Do.
7. Comprehensive health planning extension (replaced by No. 16)	S. 1632 H.R. 6583	Apr. 18, 1973 Apr. 4, 1973
8. Health facilities research and demonstration	S. 1633 H.R. 6590	Apr. 18, 1973 Apr. 4, 1973
9. Transfer of St. Elizabeths Hospital	S. 2325 H.R. 9457	Aug. 2, 1973 July 29, 1973
10. Food Processing Establishment Registration Act	S. 2416 H.R. 10899	Sept. 13, 1973 Oct. 12, 1973
11. National Health Service Corps scholarship training program	S. H.R. 11539	 Nov. 15, 1973
12. Drug Identification Act of 1973	S. 2825 H.R. 5643	Dec. 19, 1973 Mar. 14, 1973
13. Food, Drug, and Cosmetic Amendments of 1974	S. 3012 H.R. 12847	Feb. 18, 1974 Feb. 14, 1974
14. Health services program	S. 3011 H.R. 12892	Feb. 18, 1974 Feb. 19, 1974
15. Health resources planning	S. 3166 H.R. 13472	Mar. 13, 1974 Do.
16. Comprehensive Health Insurance Act of 1974	S. 2970 H.R. 12684	Feb. 6, 1974 Mar. 18, 1974
Education:		
A. Bill introduced:		
1. Higher education (extension of authorization for National Commission on the Financing of Postsecondary Education and amendment to basic educational opportunity grant program).	H.J. Res. 393 Public Law 93-35	Feb. 28, 1973 May 16, 1973
2. Elementary and secondary education (Better Schools Act)	S. 1319 H.R. 5823	Mar. 22, 1973 Mar. 20, 1973
3. Education of handicapped children	H.R. 6049	Mar. 22, 1973
4. Higher education (repeal of "grandfather" provisions in student assistance programs).	H.R. 6735	Apr. 9, 1973
5. Educational broadcasting facilities	H.R. 6872	Apr. 11, 1973
6. Elementary and secondary education (bilingual, dropout prevention, and sec. 309 Adult Education Act).	S. 1792	May 14, 1973
7. Higher education (amendments to guaranteed student loan program)	H.R. 13059	Feb. 27, 1974
B. Bills transmitted but not introduced: 1. Elementary and secondary education (Follow Through extension).		
Welfare:		
A. Bills introduced:		
1. Limitation on retroactivity of applications for social security benefits (where permanent actuarial reduction would result).	S. 2312	Aug. 1, 1973
2. International social security agreements	S. 2361	Aug. 3, 1973
3. Developmental disabilities	S. 3011	Feb. 18, 1974
4. Title VII—Aging nutrition program	S. 3100	Mar. 4, 1974
5. Headstart extension	H.R. 13425	Mar. 12, 1974
6. Juvenile delinquency	H.R. 13737	Mar. 26, 1974
B. Bills transmitted but not introduced:		
1. Aid for repatriated nationals		Feb. 25, 1973
2. OEO transfer		Mar. 26, 1974
3. Human services policy research		Mar. 27, 1974

UNCONTROLLABLES

Mr. MICHEL. You spoke this morning, Mr. Secretary, of the 94 percent so-called uncontrollables so far as your own Department is concerned, and maybe I could say as far as our committee is concerned, but really not uncontrollable so far as the balance the Congress is concerned because we are the ones who legislated these proposals; are we not?

Secretary WEINBERGER. That is correct, yes, sir.

Mr. MICHEL. Of course when the Congress by its action increased social security benefits by 7 percent and another 4 percent that was uncontrollable after we said that is what you have to do.

Secretary WEINBERGER. That is right, yes, sir.

FOREIGN MEDICAL GRADUATES

Mr. MICHEL. Mr. Secretary, you have been taking a lot of heat on the budget proposals for health manpower as indicated in the line of questioning by the chairman this morning. I even saw an article that referred to your "defense of the foreign graduate solution to America's health manpower needs." The way the article read it sounded almost as though it is administration policy to chop off health manpower funds and rely instead on foreign doctors who will work "cheaply." I hope you will tell me, Mr. Secretary, that was not an accurate portrayal or reflection of your views in whatever article I was reading.

Secretary WEINBERGER. Congressman, that was about as accurate as many of the articles I read about our Department and my recommendations, which means it was totally inaccurate. What we had said was that there are foreign medical graduates and foreign medical training. We have set our recommendations on the basis of the number of doctors that we think would be produced in the medical schools and in the other schools that train health personnel. By the 1980's we would have sufficient doctors given the needs as we can foresee them now. To increase the subsidy would perhaps result in the same kind of very dislocating surplus that we had in space scientists and schoolteachers when we supported thousands of teachers, many more than we could place because we continued the subsidy too long.

I have said as far as foreign medical graduates are concerned that the principal thing I am concerned with is whether they are trained and qualified to practice. That can only be determined by having them take tests, and if they pass those tests, I think it is the height of bigotry to say they can't practice because they happen to be trained abroad. I found that several of the most impassioned arguments against foreign medical training seem to come from those who fear they might displace doctors in this country who are trained here. I don't share this form of bigotry. It seems to me the important thing is, can a doctor qualify, can he practice, does he have the skills required by our States and crediting agencies? If he or she does, I think they ought to be licensed and allowed to practice. But we are not relying on the training in foreign schools to produce the medical manpower and personnel we need.

ADVISORY COMMITTEES TERMINATED

Mr. MICHEL. In another area, you have been terminating advisory committees right and left down there in the Department.

Secretary WEINBERGER. Yes, sir.

Mr. MICHEL. I believe the chairman asked that you supply for the record a list of those you have terminated.

Secretary WEINBERGER. I understood his request to be for those that were left. We will also supply those that have been terminated.

Mr. MICHEL. Would you do that?

Secretary WEINBERGER. Yes.
[The information follows:]

To reduce the number of committees to the minimum essential by terminating, merging, and otherwise reducing them as called for under the Federal Advisory Committee Act, Secretary Weinberger ordered the Department of Health, Education, and Welfare to conduct an exhaustive annual review during 1973. As a result a net reduction was achieved of 32 in the National Cancer Institute and 114 in the rest of HEW, for a total net reduction of 146.

This reduction from 432 to 286 committees was carried out without impairing the vital function of the advisory committee system, which is to bring to bear on problems the Government faces, the best and most balanced expertise existing outside Government.

The Department is fully committed to both goals, to optimize this application of the best and most balanced expertise, while minimizing the number and expense of the committees. We are also undertaking to carry out the whole process in accordance with the Federal Advisory Committee Act, the Freedom of Information Act, and all the other statutes applicable to advisory committee operations.

A list of the 146 advisory committees terminated, with similar data for each, is also attached. These terminations eliminated those committee costs, including an estimated 51.10 man-years of staff support, for a reduction of $2,211,913.

A list of the 146 advisory committees terminated is attached. These terminations eliminated those committee costs, including an estimated 51.10 man-years of staff support, for a reduction of $2,211,913.

Although the Department is beginning its annual review of advisory committees and is considering the termination of some of these committees, there have been no definitive plans for specific committees to be terminated.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ADVISORY COMMITTEES TERMINATED IN CALENDAR YEAR 1973

	Estimated man-years of staff support	Estimated cost
Ad Hoc Advisory Committee for the Frederick Cancer Research Center (NIH)	0.16	$6,100
Ad Hoc Committee to Review Cancer Center Support (NIH)	.04	7,000
Ad Hoc Committee for Review of the Special Virus Cancer Program (NIH)	.26	15,000
Ad Hoc Committee on Smoking and Health (NIH)	.04	1,500
Ad Hoc Committee on Testing for Environmental Chemical Carcinogens (NIH)	.04	8,500
Ad Hoc Large Bowel Cancer Committee (NIH)	.01	1,500
Ad Hoc NCI–VA Collaborative Program Review Committee (NIH)	.04	7,000
Ad Hoc Pancreas Working Group (NIH)	.02	2,550
Ad Hoc Patient Care Costs Committee (NIH)	.03	3,000
Ad Hoc Toxicology Committee (NIH)	1.00	15,000
Advisory Committee on Education of Spanish and Mexican Americans (OE)	1.00	40,000
Advisory Committee on Older Americans (OS)[1]	.66	13,466
Advisory Council on Environmental Education (OE)	.25	20,000
Advisory Council on Graduate Education (OE)[1]	0	0
Advisory Council on Library Research, Training and Resources (OE)	0	0
Advisory Council on Research and Development (OE)[1]	0	0
Allergy and Infectious Diseases Training Grant Committee (NIH)	1.00	17,000
Allied Health Professions Institutional Improvement and Training Review Committee Section A (NIH)	.10	11,246
Allied Health Professions Institutional Improvement and Training Review Committee Section B (NIH)	.10	10,590
Allied Health Professions Institutional Improvement and Training Review Committee Section C(NIH)	.10	10,090
Allied Health Professions Review Committee (NIH)	.10	9,562
Anatomical Sciences Training Committee (NIH)	.25	6,500
Anesthesiology Training Committee (NIH)	.25	9,500
Anthropology ad hoc Proposal Review Panel (NIE)	.15	11,783
Arthritis and Metabolic Diseases Program—Project Committee (NIH)	2.00	68,800
Arthritis and Metabolic Diseases Research Career Program Committee (NIH)	.05	6,000
Arthritis Training Grants Committee (NIH)	.04	11,000
Artificial Heart Assessment Panel (NIH)	.98	56,158
Behavioral Sciences Training Committee (NIH)	.25	11,000
Bioassay Operations Segment Advisory Group (NIH)	.04	8,840
Biochemistry Training Committee (NIH)	.33	16,000
Biohazards Control and Containment Working Group (NIH)	.08	4,300
Biological Models Segment Advisory Group (NIH)	.12	12,300
Biological Sciences Training Review Committee (ADAMHA)	.02	3,000
Biology and Immunology Segment Advisory Group (NIH)	.12	6,775
Biophysical Sciences Training Committee (NIH)	.25	19,000
Board of Scientific Counselors, DBS (FDA)	0	0
Breast Cancer Task Force (NIH)	.10	15,000
Breast Cancer Virus Working Group (NIH)	.32	10,100

[1] Committee mandated by statute.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ADVISORY COMMITTEES TERMINATED IN CALENDAR YEAR 1973—Continued

	Estimated man-years of staff support	Estimated cost
Cancer Cause and Prevention Advisory Committee (NIH)	0.50	$11,306
Cancer Control Cause and Prevention Review Committee (NIH)	0	0
Cancer Control Detection and Diagnosis Review Committee (NIH)	0	0
Cancer Control Rehabilitation Review Committee (NIH)	0	0
Cancer Control Treatment Review Committee (NIH)	0	0
Cancer Research Training Committee (NIH)	.33	20,333
Carcinogen Metabolism and Toxicology Segment Advisory Group (NIH)	.02	2,800
Carcinogenesis Advisory Panel (NIH)	0	0
Cardiovascular Training Committee (NIH)	.50	20,250
Chemistry and Molecular Carcinogenesis Segment Advisory Group (NIH)	.04	7,000
Child Development National Advisory Committee (OS)	0	0
Child and Family Development Research Review Committee (OS)	.10	62,000
Cholera Advisory Committee (NIH)	0	0
Clinical Cancer Training Committee (dental) (NIH)	1.00	3,163
Clinical Cancer Training Committee (general) (NIH)	1.00	8,987
Clinical and Personality Sciences Fellowship Review Committee (ADAMHA)	.17	12,000
Colon Cancer Segment Advisory Group (NIH)	.04	8,000
Committee for Young Scientists in Cancer (NIH)	0	0
Community Environmental Management National Advisory Council (HRA)	0	0
Comprehensive Health Planning Training and Studies Review Committee (HRA)	.01	2,636
Construction of Nurse Training Facilities Review Committee (NIH)	.40	10,440
Construction of Schools of Public Health Review Committee (NIH)	0	0
Cultural Anthropology Fellowship Review Committee (ADAMHA)	.17	12,000
Current Medical Procedure Terminology Technical Advisory Committee (HRA)	0	0
Dental Education Review Committee (NIH)	.25	13,600
Dental Health Research and Education Advisory Committee (HRA)	1.08	38,700
Dental Research Institutes and Special Programs Advisory Committee (NIH)	.17	7,000
Dental Training Committee (NIH)	1.00	24,000
Dermatology Training Grants Committee (NIH)	.03	5,000
Developmental Research Working Group (NIH)	.24	10,000
Diabetes and Metabolism Training Grants (NIH)	.16	19,000
Disease Control Study Section (CDC)	.02	4,600
Economics ad hoc Proposal Review Panel (NIE)	.17	13,256
Emergency Health Preparedness Advisory Committee (HRA)	0	0
Engineering in Biology and Medicine Training Committee (NIH)	.25	12,000
Environmental Sciences Training Committee (NIH)	.09	2,600
Epidemiology Advisory Committee (NIH)	.05	1,500
Epidemiology and Biometry Training Committee (NIH)	.25	8,000
Erythropoietin Committee (NIH)	.01	0
Fogarty International Center Board of Advisors (NIH)	0	0
Gastroenterology and Nutrition Training Grants Committee (NIH)	.40	26,000
General Research Study Section (SRS)	.10	4,173
Genetics Training Committee (NIH)	.25	1,200
Gerontology Research Center Resources Advisory Committee (NIH)	0	0
Grants Administration Advisory Committee (OS)	.10	7,500
Growth and Development Research and Training Committee (NIH)	.30	10,000
Head Start National Advisory Committee (OS)	0	0
Health Manpower Opportunity Advisory Committee (NIH)	.50	17,900
Health Research Facilities Scientific Review Committee (NIH)	0	0
Hematology Training Grants Committee (NIH)	.12	35,000
History of Life Sciences Study Section (NIH)	.30	10,000
Human Development ad hoc Proposal Review Panel (NIE)	.19	14,729
Immunology-Epidemiology Working Group (NIH)	.42	16,660
Information and Resources Segment Advisory Group (NIH)	.04	3,500
International Centers Committee (NIH)	.30	36,000
International Fellowship Review Committee (NIH)	1.50	35,377
Learning and Instruction ad hoc Proposal Review Panel (NIE)	.40	30,932
Loan Guarantee Programs in Health Advisory Committee (HRA)	.20	1,334
Lung Cancer Segment Advisory Group (NIH)	.05	5,000
Medical Assistance Advisory Council (SRS)[1]	0	0
Medical Care and Medical Economics Advisory Committee (NIH)	.05	1,500
Medical Education Review Committee (NIH)	.50	29,400
Medical Research Study Section (SRS)	.10	4,300
Medical Scientist Training Committee (NIH)	.25	20,000
Mental Health New Careers Training Review Committee (ADAMHA)	.50	18,000
Microbiology Training Committee (NIH)	.33	10,700
Multiple Sclerosis ad hoc Scientific Advisory Committee (NIH)	.50	48,000
Myocardial infarction Committee (NIH)	.01	5,000
National Advisory Allied Health Professions Council (NIH)	.18	3,639
National Advisory Committee on Consumer Product Safety (FDA)	0	0
National Advisory Committee on Education of the Deaf (OE)[1]	1.00	17,059
National Advisory Committee on Handicapped Children (OE)[1]	1.00	27,045
National Advisory Committee on Services for the Blind and Visually Handicapped (SRS)	.22	11,825
National Advisory Council for Disease Control (CDC)	0	0
National Advisory Council on Vocational Rehabilitation (SRS)[1]	.75	17,816
National Head and Neck Cancer Cadre (NIH)	.04	21,150
National Heart, Blood Vessel, Lung and Blood Program Committee (NIH)	1.50	200,000
National Policy and Performance Council (SRS)[1]	0	0

[1] Committee mandated by statute.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ADVISORY COMMITTEES TERMINATED IN CALENDAR YEAR 1973—Continued

	Estimated man-years of staff support	Estimated cost
		3
Neurological Science Research Training A Committee (NIH)	0.70	25,333
Neurological Science Research Training B Committee (NIH)	.70	25,330
NIMH Communications Advisory Committee (ADAMHA)	.10	1401
Nurse-Scientist Graduate Training Committee (NIH)	.45	10,441
Nurse Training Act Project Grants Review Committee (HRA)	1.10	59,830
Nurse Training Review Committee (ADAMHA)	.08	8,600
Nutritional Sciences Training Committee (NIH)	.12	3,30
Objectives, Measurement, Evaluation and Research Methodology ad hoc Proposal Review Panel (NIE)	.15	11,783
Optometry, Pharmacy, Podiatry and Veterinary Medical Education Review Committee (NIH)	1.00	13,600
Organization and Administration ad hoc Proposal Review Panel (NIE)	.19	14,729
Orthopedics Training Committee (NIH)	.04	3,000
Pathology Training Committee (NIH)	.25	12,000
Perinatal Biology and Infant Mortality Research and Training Committee (NIH)	.60	20,000
Pharmacologic and Clinical Approaches in Smoking Working Group (NIH)	.60	10,000
Physiology Training Committee (NIH)	.25	9,000
Political Science and Legal Research ad hoc Proposal Review Panel (NIE)	.30	23,567
Preventive Medicine and Dentistry Review Committee (NIH)	.10	6,968
Psychiatry Training Review Committee (ADAMHA)	.20	18,290
Psychological Sciences Fellowship Review Committee (ADAMHA)	.17	12,000
Psychology Training Review Committee (ADAMHA)	.01	8,790
Psycho-Social Study Section (SRS)	0	0
Public Health Review Committee (NIH)	.10	18,279
Pulmonary Training Committee (NIH)	.50	20,250
Radiological Health Research and Training Grants Review Committee (FDA)	.30	10,000
Radiology Training Committee (NIH)	.25	8,000
Regional Health Advisory Committee, Region I (HRA)	.03	2,000
Regional Health Advisory Committee, Region II (HRA)	.09	1,757
Regional Health Advisory Committee, Region III (HRA)	.12	3,000
Regional Health Advisory Committee, Region IV (HRA)	.02	500
Regional Health Advisory Committee, Region V (HRA)	.06	850
Regional Health Advisory Committee, Region VI (HRA)	0	0
Regional Health Advisory Committee, Region VII (HRA)	0	0
Regional Health Advisory Committee, Region VIII (HRA)	0	0
Regional Health Advisory Committee, Region IX (HRA)	0	0
Regional Medical Programs Review Committee (HRA)	1.60	16,896
Renal Disease and Urology Training Grants Committee (NIH)	.30	26,000
Research Resources Committee (NIH)	.25	15,000
Research Scientist Development Review Committee (ADAMHA)	.25	4,300
Secretary's Advisory Committee on Automated Personal Data System (OS)	5.00	79,000
Secretary's Advisory Committee, Region I (OS)	0	0
Secretary's Advisory Committee, Region II (OS)	0	0
Secretary's Advisory Committee, Region III (OS)	0	0
Secretary's Advisory Committee, Region IV (OS)	0	0
Secretary's Advisory Committee, Region V (OS)	0	0
Secretary's Advisory Committee, Region VI (OS)	0	0
Secretary's Advisory Committee, Region VII (OS)	0	0
Secretary's Advisory Committee, Region VIII (OS)	0	0
Secretary's Advisory Committee, Region IX (OS)	0	0
Secretary's Advisory Committee, Region X (OS)		
Sensory Study Section (SRS)	0	0
Small Grants ad hoc Proposal Review Panel (NIE)	.44	33,947
Social Sciences Training Review Committee (ADAMHA)	.02	3,000
Social Thought and Processes ad hoc Proposal Review Panel (NIE)	.19	14,729
Social Work Training Review Committee (ADAMHA)	.08	6,498
SRS Manpower Development National Advisory Committee (SRS)	0	0
Surgery Training Committee (NIH)	.25	13,000
Technical Advisory Committee on Aging Research (OS)	.91	26,872
Tumor Virus Detection Working Group (NIH)	.18	10,000
Tuskegee Syphilis Study ad hoc Advisory Panel (OS)	2.50	90,000
Ultraviolet Radiation and Skin Cancer Working Group (NIH)	.50	4,000
U.S. National Committee on Vital and Health Statistics, Financial Data Year Planning Subcommittee (HRA)	0	0
U.S. National Committee on Vital and Health Statistics, International Classification of Diseases Subcommittee (HRA)	0	0
U.S. National Committee on Vital and Health Statistics, Uniform Hospital Abstract Form Subcommittee (HRA)	0	0
U.S. National Committee on Vital and Health Statistics, Working Party on Classification of Mental Disorders of the International Classification of Diseases Subcommittee (HRA)	0	0
U.S. National Committee on Vital and Health Statistics, Working Party on Classification of Neoplasms of the International Classification of Diseases Subcommittee (HRA)	0	0
Working Committee for the International Registry of Tumor Immunotherapy (NIH)	0	0
Total estimate	51.10	2,211,913

Mr. **Michel.** Would that include those that are in the process of being disbanded?

Secretary **Weinberger.** Yes, we could do that. I think we aren't very much in the in-between stage. We have either abolished them or are still continuing them.

COST OF ADVISORY COMMITTEES

Mr. **Michel.** Have you any ball park figure of what all of these advisory committees cost us in your budget?

Secretary **Weinberger.** I would be guessing. We had over 400 of them when I came to the Department. I think we are now down to the 260 range, something of that kind. As for total figures, I would be guessing. I am getting a note here that the energy used and the amount of funds involved could heat one house for 635 years. I think that is a reasonably good start on the information you have in mind.

Mr. **Michel.** Of course the Congress itself has mandated some of these advisory committees.

Secretary **Weinberger.** Obviously we have not abolished the ones statutorily required but there is a very large number that have been created by Departmental or Presidential Order, and those we felt somewhat freer to move on.

ROLE OF FEDERAL GOVERNMENT IN HEALTH CARE

Mr. **Michel.** In your testimony last year the limited role of the Federal Government in health care was being stressed, and you emphasized that it shouldn't be the solution of first resort. Dr. Edwards said that to do this would be to determine in advance that our public and private institutions and social structures are hopeless failures and can never be expected to serve the American people adequately and equitably.

Do you feel that way?

Secretary **Weinberger.** Yes. I don't think the Federal Government should deliver health care services except in very specified cases such as the Veterans Administration Hospital services. I think the Federal Government should have its principal role in the delivery of health care services to the public not in the actual delivery but in specialized training, in the provision of the insurance program that we are talking about, in research and development, in dissemination of that research, and in specialized fields of that kind. I don't believe the Federal Government should open or operate hospitals or run doctor's offices for the general public.

This was one of the reasons we also felt that the in-patient services at Public Health Service hospitals should be phased out, because we felt there was no longer the need that existed in 1789 when that system started.

NATIONAL HEALTH STRATEGY

Mr. **Michel.** A few days ago the Under Secretary testified on the administration's health planning and rate regulation legislation, and he suggested that this proposal be considered "within a total national strategy to resolve our major health problems of access, cost and quality of care."

Secretary WEINBERGER. I would agree with that.

Mr. MICHEL. What is this total national strategy? What are the other parts of it?

Secretary WEINBERGER. One of the other elements, of course, is the comprehensive health insurance plan which has been introduced and we hope will have hearings start very soon.

Another part of the plan, of course, is the research work that we do do at the National Institutes and elsewhere.

Another part of it, of course, is the manpower training, the legislation we will have before you shortly.

Another part would be the health planning agencies legislation which has been introduced and represents our recommendations with respect to consolidating and improving the health planning effort of the country aided by the Federal Government.

These are some of the individual pieces of it. Of course the PSRO program which we spoke about earlier and cost control would be an integral part of the health insurance plan itself.

PROFESSIONAL STANDARDS REVIEW ORGANIZATION

Mr. MICHEL. You lead, really, into my next line of questioning which has to do with PSRO's. Do you think, Mr. Secretary, the controversy that has been generated over the PSRO efforts will have a negative effect on consideration of comprehensive health insurance proposals?

Secretary WEINBERGER. I would hope not. I would hope that it would be viewed as simply the normal worry that comes when a very far reaching piece of legislation that can affect the private practice of medicine is put into effect. As I mentioned this morning to the chairman we are firmly committed to the idea of administering this legislation in the way that will not put the Government in the dominant role of trying to practice medicine or say how medicine should be practiced. We are going to carry out the intention of the Congress, and we hope that we can administer it in a way that would be complimentary to and part of the national health insurance efforts.

Mr. MICHEL. This morning, Mr. Secretary, you stated the PSRO's came about as a result of a conference between the House and Senate in which we did not really have any debate.

Secretary WEINBERGER. As I understand it, no hearings and practically no debate.

Mr. MICHEL. Right. And we have had a running controversy out in my home State of Illinois on them too. If we had not had that built into the act as a result of that conference, have you thought about what type of approach the Department would have taken to give this kind of oversight or review without generating all of this turmoil we get in the hustings?

Secretary WEINBERGER. The thing that strikes us as being most essential, Congressman, is the need to establish some kind of workable cost controls in this field. We had enormous inflation, escalation that came about after medicare and medicaid were adopted in the mid-sixties. I think we had that because of faulty designs in those programs that encouraged overuse of hospitals and also authorized and directed repayment of claims in any amount submitted by any provider.

I think when you put those together with the shortage of medical manpower that existed then, which we believe has been corrected now, you have all the classic ingredients for a tremendously sharp inflationary rise in the cost of health services, particularly hospitalization. And indeed that came about.

In short, with the Federal Government now into this field at the rate of about $20 billion a year we don't have a free market, and as a result I think you do need to have some kind of control on the cost of health services. We have so recommended to the President, and that is an integral part of our health insurance bill.

I think that even if we had not had PSRO, which is not fundamentally a cost control measure at all—in fact the language indicates it is specifically not to be used for that purpose—we nevertheless would have had to have some kind of utilization review committees for hospitalization, which in fact we have, and we would also have had to make some effort to establish what is proper, reasonable, and necessary services to be performed by physicians so we could determine what should and should not be reimbursed. We could then determine when a claim came in, as I mentioned this morning, for seven house visits in one day, we would have some basis for saying that that is overutilization and we aren't going to reimburse for it. We would need to hold down both the individual costs of services as well as the overuse of Government-reimbursed services.

Mr. MICHEL. Are there any statewide PSRO's?

Secretary WEINBERGER. Yes, sir.

Mr. MICHEL. Could we have those listed for the record?

Secretary WEINBERGER. Yes. There is one in Utah and one in Colorado. You mean those we have designated or those which are in existence now?

Mr. MICHEL. That you have designated as a PSRO unit.

Secretary WEINBERGER. Roughly half of the States are designated as single State PSRO's.

Mr. MICHEL. You are aware in my home State of Illinois there was quite a concerted effort to have the whole State designated?

Secretary WEINBERGER. I recall that. We do have a congressional direction that we have to follow in setting up the district lines, the boundary lines for PSRO's, and wherever we possibly could we tried to honor the individual request.

In California, for example, they wanted more PSRO's than we had originally designated. In some States they wanted a single State one. We did as much as we could within the guidelines in the statute, and we certainly did not achieve results which satisfied everybody.

Mr. FLOOD. Will the gentleman yield?

Mr. MICHEL. Yes.

Mr. FLOOD. It is the State medical societies in conjunction with other State people who set up the PSRO jurisdiction, isn't?

Secretary WEINBERGER. No; we were required to do that.

Mr. FLOOD. But not in Washington. You didn't set it up here. Don't you set it up through your regional people?

Secretary WEINBERGER. We established the boundary lines here. The PSRO's within those boundaries, within those individual districts, will be formed on application of the people who want to form them. That is the way the statute works.

Mr. FLOOD. I was concerned about it.

Secretary WEINBERGER. The applications will come through the regional offices.

Mr. FLOOD. I was concerned about who set up the designated areas.

Secretary WEINBERGER. We were required to do that here and we did that.

HEALTH PLANNING

Mr. MICHEL. Are you proposing in your new health planning and rate regulation bill to finance use of these same areas as health planning agency areas that require coordination with the PSRO and surveillance.

Secretary WEINBERGER. No.

Mr. CARLUCCI. The bill would require us to take PSRO areas into account in determining the health planning areas as well as taking into account sub-State planning districts.

STATUTORY GUIDELINES FOR PSRO'S

Mr. CASEY. What were the guidelines that you felt bound you to disagree violently, so to speak, with what the medical profession desired?

Secretary WEINBERGER. The typical case, Congressman, was the situation in which a State medical society would want to be designated as a single State PSRO for the entire State, but we found very wide diversity of practice within that State. For example, there may be a couple of large cities and some very extensive rural areas in the State. The practice of medicine would differ rather widely within that State, and the basic guidelines that we had to follow were to try to get the areas of the State that had a similar type of medical practice, similar type of patients, similar conditions, into one area. Wherever we could, if the State wanted a statewide PSRO, we went along with that. But we had some States where we felt that the congressional guidelines forbade us from designating a statewide PSRO. As a result we had to use three or four in one case. I have forgotten how many Pennsylvania had. California I think had 26. There were these kinds of variations. But there were guidelines in the statute that we felt had to be followed, and we tried to set forth those guidelines in our original regulations.

Mr. CASEY. Put the statutory guidelines you referred to in the record at this point.

Secretary WEINBERGER. Yes.

[The information follows:]

PSRO AREA DESIGNATION GUIDELINES

Section 1152(a) of part B, title XI of the Social Security Act directs the Secretary to "(1) establish throughout the United States appropriate areas with respect to which PSRO's may be designated; and (2) at the earliest practicable date after designation of an area, enter into an agreement with a qualified organization whereby such an organization shall be conditionally designated as the PSRO for such an area."

The statute, however, does not define the term "appropriate areas"; and, in the absence of a statutory definition, it is incumbent upon the Secretary to develop administrative criteria and guidelines for this purpose, having in mind the basic purposes of the statute.

From a review of the statute and the legislative history, the following guidelines were developed for designating appropriate PSRO service areas:

1. *In general, a PSRO area should not cross State lines.*—The basis for this guideline is the provision of the law relating to the creation of statewide councils and the several references in the Senate Finance Committee report to

areas established on a multicounty or State basis. In addition, the medicaid program is organized on a State-by-State basis.

2. *In general, a PSRO area should not divide a county.*—Considerations of administrative practicability serve as the basis for this guideline. However, in instances of large geographic areas or large county populations, it may be necessary and appropriate to cross county lines.

3. *Existing boundaries of local medical review organizations and health planning areas should be considered.*—Since the Senate Finance Committee report recognizes the existence of local professional medical review organizations, the current boundaries of these organizations should be considered. In addition, established health planning areas need to be considered as possible precedents.

4. *A PSRO area should, to the extent possible, coincide with a medical service area and assure broad, diverse representation of all medical specialties.*—The PSRO area should be drawn to include, to the extent possible, the existing medical service or medical trade areas. Consideration should be given to existing medical centers and to natural geographic barriers. In addition, effective peer review is attainable only if the review body has available to it the necessary range of professional expertise.

5. *A PSRO area should generally include a minimum of approximately 300 licensed, practicing physicians. While the maximum can be expected to vary with local circumstances, generally, it should not exceed 2,500 licensed, practicing physicians.*—The purpose of an approximate limitation on the maximum size of an area's physician population is to emphasize the statutory concepts of local peer review responsibility and the active participation of local practicing physicians in the activities of the PSRO.

6. *The designation of a PSRO area should take into account the need to allow effective coordination with medicare/medicaid fiscal areas.*—This principle is stated in the statute and the Senate Finance Committee report. Since the PSRO is involved in the medicare and medicaid program, it will have a significant effect on the claims process.

ESTABLISHMENT OF PSRO AREAS

Mr. Flood. Mr. Secretary, how do you establish a jurisdiction? I was advised by your office that the actual delineation of jurisdictions was made by the State of Pennsylvania people and then sent to you. Did they make the final determination or did you merely ask their aid?

Secretary Weinberger. We asked for the recommendations and the advice of a great number of people including the medical societies, because the statute says the PSRO's are to be run by the doctors themselves unless they refuse, and then it says we have to do it.

So we went to the various medical organizations as well as a number of others. They made recommendations. We published a preliminary rule or regulation in December in the Federal Register. We extended the time for comments, and on March 18 we published the final regulation which set the boundary lines after all of these discussions and recommendations, and our own consideration of the statutory guidelines that we felt the Congress had wanted us to follow. As a result we have some cases where there are single State PSRO's, about half the States. In some there are many PSRO's within a State. In each case we tried to get as much advice and recommendation as we could and to follow the recommendations and wishes of—for example—the State medical society if that was practical, if they were going to run the PSRO.

Mr. Carlucci. In addition, Mr. Chairman, we are going out with contracts to certain States that want to set up a State technical support center for PSRO's. Hence, even though you may have multiple PSRO's in a State you could also have a statewide technical assistant program.

Mr. Michel. Wouldn't that be the case in Illinois?

Mr. CARLUCCI. Yes, and it would be the case in Pennsylvania.

Mr. FLOOD. I was talking about the Medical Society.

Mr. CARLUCCI. In the State of Pennsylvania it is my understanding it will be the society. The society is coming in to request a contract to be a statewide support center even though the PSRO's are local entities. So you may have multiple PSRO's within a State, but you could also have a statewide support center.

Secretary WEINBERGER. This would do such things as provide the computer services to all of the PSRO's within the State. It would finance on a common basis some of the overhead and administrative costs of all of the PSRO's, since they would be working in close relationship.

OPPOSITION OF MEDICAL PROFESSION

Mr. FLOOD. I ask that question because of the opposition developing from the medics themselves and from the top office of the AMA. I thought we should have something about that.

Secretary WEINBERGER. There are two kinds of opposition, Mr. Chairman. There are probably several kinds but two kinds we hear about particularly. One is the desire to have a single State PSRO or to have different boundary lines than we felt we were able to set. The other is a fundamental opposition to the whole program, exemplified perhaps by a resolution at the AMA convention last year that sounded as if they wanted to repeal the whole program. But there is some ambivalence about this. There have also been reports that some of the doctors have been asked not to participate and so on.

The statute provides that the doctors man and run the PSRO's. If they do not, we are required under the statute to appoint other people to do it. This is a responsibility I hope I don't have to exercise.

Mr. MICHEL. Physicians are already expressing some concern about the amount of data they are going to have to put together here for the PSRO's.

Secretary WEINBERGER. There is no question there is going to be a lot of material that will have to be assembled. Essentially what the PSRO's are going to try to do is to set up what we might call a screen against which to measure medical services with respect to quality, utilization, and necessity in the various different areas of the country.

They are going to go into, I imagine, such things as proper and normal lengths of stays in hospitals, the types of medication and procedures to be used, and things of that kind.

This is a very far-reaching and a potentially intrusive kind of activity.

It should be borne in mind however, that there are a great many PSRO's in existence now—before the statute—organized by doctors and run by doctors that are working very well. These include the San Joaquin Medical Foundation in California, statewide PSRO in Colorado, statewide PSRO in Utah where they have been doing this and have experience with it for quite some time. So it can be operated in a way that is beneficial. But there is a great deal of data that will have to be assembled and that is why we are talking about statewide support centers involving common use of computers to serve PSRO's throughout a State when a single computer would be too expensive for each PSRO to use itself.

MEDICARE AND MEDICAID PAYMENTS TO DOCTORS

Mr. MICHEL. This morning you made mention of that Chicago Tribune headline which really caught my attention, too, with respect to those doctors in Illinois that had incomes up to $477,000, I think, in the case of one, for medicare and medicaid.

Secretary WEINBERGER. Yes.

Mr. MICHEL. Nowhere in that article however, did I get the impression that these could have been doctor's offices where there was more than the one doctor actually involved in the office, or a number of nurses—in other words a complex rather than an individual doctor. Is this the case?

Secretary WEINBERGER. It could be. There were similar articles about the District of Columbia doctors a while back, and there was one who was listed as having an income in excess of $300,000 for a single year for medicare-medicaid patients. He had what I believe he termed, or perhaps the newspaper called, an assembly line operation in which he managed to see 40 and 50 patients in a morning. He did have a staff. Of course he had nurses and he had some laboratory work done there.

The thing in the article that intrigued me was the very last paragraph, because after listing all of this and the $300,000 income it said "Of course this doesn't include another $175,000 he makes from Blue Cross." That was never explained. But he obviously had some kind of fairly substantial operation going to do that.

What we are concerned with is not whether he does this or whether he performs the services; it is whether or not that constitutes some kind of explicit claim against the Government for those services which could result in substantially inflating total Federal expenditures, and also result in increasing the costs of medical services generally since these programs are now so big that they tend to drive the cost of all medical services up.

PREADMISSION CERTIFICATION

Mr. MICHEL. Mr. Secretary, two recent administration actions have stirred up a storm of controversy. One was the proposal to require approval of all nonemergency medicare-medicaid admission before a patient can get a hospital bed. The other was a set of new phase 4 hospital controls limiting the hospital increases to 7½ percent per admission.

It has been charged both rules could seriously lower the quality of medical care. Do you have any comment on those charges?

Secretary WEINBERGER. Yes, sir. With respect to the first, called the preadmission certification, this is an academic subject at the moment because I withdrew the proposed legislation. I became convinced from the discussions you mentioned that the doctors themselves wouldn't participate in the program.

Basically it is a program in which the hospital establishes an admission certification committee made up of doctors who would decide—obviously in nonemergency cases because emergency cases would of course be admitted—whether hospitalization was absolutely essential and if so, what would be the estimated length of stay. This was designed to try to get some consciousness on the part of the hospital and the doctors themselves of the extra cost to the Government of unnecessary admissions to hospitals under the medicare-medicaid programs.

The system will only work if doctors participate in it. It has been in effect in California for some years, and the doctors do participate in it. It has had a beneficial effect and worked well there. But it will not work if doctors won't participate, and the protests that you mentioned convinced me they would not. So we withdrew it and are now trying to develop some kind of utilization review procedures that will be effective but will have the effect of trying to reduce the rapidly increasing costs to the Government of hospitalizations where we think in many cases some other, less expensive mode of treatment would be even more beneficial to the patient. That is essentially where that originated and where we are on it.

With respect to the phase 4 regulations of the Cost of Living Council, they did attempt to give some leeway to hospitals which were contending, because they remained under the price freeze and were one of the last remaining portions of the consumer index group to remain under controls, that they were being unfairly treated since some of their suppliers were not under controls and their costs were rising. This was an attempt to give them some additional opportunity to recognize and pass on increased costs without the kind of rapid inflation that has taken place.

Hospital care now is in excess of $120 a day on the average and in some parts of the country it is in excess of $146 a day. That had gone up on the consumer price index in an almost perpendicular fashion until 1971 when the price controls were begun. Thus there has been a continuing attempt by the administration to try to hold down the cost of health care.

REGIONAL MEDICAL PROGRAM

Mr. MICHEL. In February you wrote us about a serious problem you are facing with respect to the regional medical program. On February 7 the court ordered you to obligate all of the 1973 and 1974 moneys with "such speed as is administratively feasible." And you said, "We are doing so reluctantly, feeling that better use could be made of these funds."

I think that is essentially correct, is it not?

Secretary WEINBERGER. Yes, sir.

Mr. MICHEL. Where are we now? What has happened? Are you in the position where you are just shoveling out the money to meet this court order and it is just being frittered away?

Secretary WEINBERGER. That would be one way to do it, but we have rejected that approach. That is the "rat hole" syndrome which we have tried to avoid.

Mr. Carlucci can probably give you the up-to-date figures on it. We are making an effort to comply with the court order, but we are also conscious of the fact as to how much can be wasted when you just "shovel it out."

Mr. CARLUCCI. We received a letter back from the chairman of this committee indicating that he did not go along with our proposal. We heard from some of the other committees also. The Rogers subcommittee has asked us for a legislative proposal, and in fact I am going to have a meeting in my office at 4:45 this afternoon to discuss what kind of legislation might be submitted.

You will recall in the letter we suggested that perhaps these funds could be utilized more effectively for such critical health problems as the problems of inner city hospitals or the problem of getting nursing homes up to safety code standards.

Mr. FLOOD. Mr. Obey.

Secretary WEINBERGER. Could I interrupt and put the figures in the record we were talking about with Mr. Michel a moment ago?

Mr. FLOOD. Yes.

Secreatry WEINBERGER. These are the regional medical funds left so to speak. There is $89.9 million of 1973 money which we have until February to expend, and there is $31.6 million of 1974 money which we have until June of this year to expend. Those are the funds that we are talking about when we say we are trying to allocate them in a responsible way. We have made recommendations as to how we think it might be more responsibly done.

Mr. FLOOD. Mr. Obey.

ADVISORY COMMITTEES MEETINGS

Mr. OBEY. Mr. Secretary, a variety of questions. First of all, let me ask a question on advisory committees.

Secretary WEINBERGER. Yes.

Mr. OBEY. My office did a survey of the number of advisory committees who were meeting in compliance with the open meeting laws, and we found out that in the 2-week period which we surveyed, 42 percent of the advisory committees were meeting in violation of that open meeting requirement.

I know that HEW has been making a solid effort to keep those advisory committee meetings open, probably better than most other agencies. But I did want to ask you if you had any idea of what percentage of your advisory committees were meeting in compliance with the law?

Secretary WEINBERGER. We have very firm and very easily understood instructions out that explain what the law says and how they are all to comply with it.

I am only aware of one incidence where there was a challenge to it in recent months, and we took steps to correct that. I don't know if we have any other figures of that kind.

I appreciate your comments, Congressman Obey, and we are making that kind of effort. I am not aware of any violations of this.

Mr. OBEY. For instance, a practice we have seen consistently has been advisory committees putting notices of their meeting in the Federal Register virtually the same day of, or the day before, the meeting. So there is a technical compliance, I suppose, but in terms of anybody being able to actually attend that meeting or cover it as a reporter, it is a virtual impossibility.

To your knowledge has that practice been pervasive?

Secretary WEINBERGER. Not recently. I am not aware of the previous practice. Again our instructions are that the notice is to be realistic, have some meaning, and be submitted in time so that those members of the public will have an opportunity to come if they wish to do so. But when you have over 400 of these committees it is always possible that one or two of them may not be complying with your instructions. We would hear about it from protests following which we would immediately act.

But we are trying, as I said, to reduce the number of these committees substantially, and we are in at about 260 at the moment and still going down.

If there are any specific violations that you are aware of, be sure and let us know because the instructions were not issued in a vacuum. They are meant to be complied with, and we would like to know if there is some evidence of violations. I don't know of any at the moment.

Mr. OBEY. I appreciate that because it makes those of us in the Congress who have been requiring our own committees for instance to meet in open session look a little silly when we are asking that of our own committees and find out that advisory committees are ignoring the law and the wishes of the Congress.

ADVISORY COMMITTEE STAFF SALARIES

I noticed in the paper last week I guess that the Director of HEW Advisory Committee on, I believe, vocational education, is paid $42,888 a year.

Secretary WEINBERGER. We noticed that too. We have a series of guidelines now with staff recommendations, staffing patterns, and salary schedules that we are putting into effect. We have a problem with that committee because, as I remember it, that is a statutory commission and we can't take the short, easy road of abolishing it. But we do have some problems with the staffing patterns and the salary schedules that have gone along with some of those committees.

Mr. CARLUCCI. I should point out, if I may, that that $42,800—and I am very conscious of it since it is considerably higher than the Under Secretary's salary—was not all salary. I believe the salary was $36,000 and the rest of it was benefits paid out of the fund used to support the Advisory Committee. As you know, when we have a statutory advisory committee we have to give that committee funds which it has control of. It is my understanding there were efforts to get that under control but we haven't been successful yet. We will continue to try.

Mrs. GREEN. Will the gentleman yield?

Mr. OBEY. Yes.

Mrs. GREEN. You mean he only paid taxes on $36,000 and received the other as fringe benefits?

Mr. CARLUCCI. I haven't seen his tax returns, but my understanding is the rest of it is fringe benefits.

Secretary WEINBERGER. The problem is the Under Secretary was thinking of applying for the job and I have had a terrible time keeping him from it.

DRUG REIMBURSEMENT

Mr. OBEY. Let me ask you something else. Again I want to commend you for what I understand your position to be in determining that you will buy medication at the lowest available prices on the drug market. As I understand it, Dr. Edwards told the Senate subcommittee you were having some difficulty with that proposal, but said there would not be any backtracking from it.

Secretary **Weinberger**. There is no backtracking from it. There are some administrative problems in drafting the regulations.

Essentially the problem is that what we are talking about is the amount the Government would pay in reimbursement of a claim for prescription drugs. We have established the basic principle that we would reimburse for the medication ordered by the doctor at the lowest possible rate that medication, under whatever name it might come, could be obtained. And there are some administrative problems in establishing the notice to the providers, to the hospital pharmacies, and the retail drug stores and so on that this is to be the reimbursement policy.

We don't want the burden or brunt of that to fall on the patient himself, and we want to have a sufficient notice to all that this is the policy as to what the amount would be for the most commonly prescribed medicine.

But there is no deviation from the basic principle or the basic policy of reimbursing at the lowest possible cost for the medication which the doctor prescribes.

We also, as I told the Senate committee, are not planning to substitute ourselves for the doctors in making prescriptions. But when a doctor prescribes a drug under one name that can be obtained under another name at a lower price, then we will reimburse for that lower price.

Mr. **Flood**. Mr. Michel.

EXCESS HOSPITAL BEDS

Mr. **Michel**. Mr. Secretary, last year the Washington Post ran a series of articles entitled "Our Unplanned Hospitals." I am sure you and some of our cohorts remember that series of articles. The series explored our local hospital building frenzy in the Washington area. It was about that time the HMO legislation went through the House, and I recall making the point that "hospital" has been a magic word in the Congress for far too many years, and no one in the Congress here I guess feels that an antihospital vote back home is good politics. So we continue to fund programs and stimulate the overbuilding of hospitals and in the areas that need them least.

I guess the effect is just the opposite of what we want, because these extra beds result in higher health costs increased insurance costs, higher taxes, deterioration of quality of health care, and so on.

I was going to ask a question, but I probably have given your response to it. Are we on the same wave length on that?

Secretary **Weinberger**. We are. This is why we recommend the Hill-Burton abolition, and what you mentioned as to the results that come from overbuilding are exactly correct. It just means higher costs.

Mr. **Michel**. In response to the chairman this morning when he voiced his concern with respect to the phasing out of Hill-Burton, raising the question how do we expect this modernization program to go forward, your response in part was that there is sufficient reimbursement in medicaid-medicare and cranking up of costs to provide for that. And I think you mentioned a figure of $1 billion or more.

Mr. **Young**. $1 billion from the private sector and about $700 million from the Government. It is almost $2 billion this current year.

HOSPITAL DEPRECIATION ALLOWANCE

Mr. MICHEL. Now do we have hard and fast information that would indicate that the money being cranked into this reimbursement is actually being utilized to provide for modernization of existing hospital facilities, or is this just there as a cushion?

Secretary WEINBERGER. It is available for that purpose, and the reimbursement is claimed for the purpose of setting up depreciation reserves looking toward the replacement of facilities in the institutions that make the claim.

There are certainly a substantial number of rehabilitation and restoration projects going on. There are also, sadly, too many projects still going on that involve duplication of services.

We now have in the Social Security Act a provision that enables us to have the States review and approve applications for Federal support. Also we can deny reimbursement to institutions that are added to contrary to State findings of necessity. In our health insurance bill we have extended that kind of provision so that we could get control through the States themselves of overbuilding or unnecessary building that, as you say, adds to the cost.

Mr. CARLUCCI. Mr. Michel that is section 1122 of the Social Security Act, and it does require that the State make this construction review before medicare and medicaid can pay for depreciation. So the direct answer to your question is that is how we insure that the funds are going for the purpose designed, that is, modernization.

Mr. MICHEL. But we really have no figures available if I asked you to place in the record the number of hospital modernization projects around the country today that are being financed in the main by the fund we are talking about here. Or is it too soon.

Secretary WEINBERGER. The section was passed in the fall of 1972. It is a little soon for any data to have been assembled. We could get what we could for you.

I think the important point is that the funds are available. There are also private funds of course available. This is why we don't think it is necessary to continue allocating scarce Federal resources for a purpose that is already taken care of.

REVENUE SHARING

Mr. MICHEL. Do we have any figures available at all on what the State and local communities are doing with their general revenue sharing money in the field of health and welfare for example?

Secretary WEINBERGER. We know that the bulk of those funds are going primarily for educational purposes. We also know that the first year—and we don't have the full first year figures— is apt to be somewhat distorted by backed up, pent up priorities held back because the States and local governments have not had sufficient funds. But public safety and schools were the principal items the first year.

I would be reasonably sure that they would make greater use of these funds for health in the years ahead as they satisfy some of their other priorities. But the theory that these funds were being wasted I think has been very substantially disproved.

Mr. YOUNG. The first full report was issued just recently by the Treasury Department which gives the distribution. We have it here.

HEW INVESTIGATIVE UNIT

Mr. MICHEL. I think in the latter part of your testimony you made a plea for us to reconsider the action to reduce the investigate unit in HEW's Office of Administration.

Secretary WEINBERGER. Yes, sir.

Mr. MICHEL. What do you have now in positions?

Secretary WEINBERGER. I think we have an authorization of eight. If I might set the background of that, Congressman, those eight people help us administer a grant program in which there are 43,600 grants and 26,000 contracts with a total of close to $8 billion. What we want the additional people for is to enable us to give you the assurance that these grantees are administering the funds wisely and well for the intended purpose, that there are no conflicts of interest, that there has been no dishonesty or bribery in obtaining them and things of that kind. We think this force is quite inadequate.

Mr. MICHEL. You want 20 in the 1975 request as against 8.

Secretary WEINBERGER. Yes.

Mr. MICHEL. I have heard it said on the other side of the Capitol this might be comparable to the "Plumbers unit" in the White House.

Mr. FLOOD. Of course you do have a tremendous and very good audit unit in your department, a big audit unit.

Secretary WEINBERGER. We have an audit unit. I wouldn't characterize it as tremendous.

Mr. FLOOD. It is very good.

Secretary WEINBERGER. Yes, we think it is good. We are trying to improve it, but we think it is very good.

Incidentally the food stamp program which is a little under $4 billion has 75 of these people.

Congressman Michel, you used the expression that the other House has used in describing this unit as a so-called "Plumbers unit." I can't think of anything that would either be more infuriating to me or more totally inaccurate, and I have so expressed myself to the Members on the other side who used this term, because this unit is designed for no other purpose than to assure the Congress and the public that these very large sums of money and enormous numbers of individual grants are being wisely and properly allocated, free from any corruption or dishonesty in the allocation, and are being managed properly. With 43,600 grants I always have the continuing nightmare that one or two of them may go wrong.

If we had eight people looking into it, compared with 75 people in the food stamp program with a lot less money, you have a rough idea of the kind of workload we feel is necessary. But we do not intend to use them nor have we used them for any purpose other than to enable us to assure the public and the Congress that these grants and contracts are awarded in a way that is free of corruption, that they are being well and properly managed, and that they are using the money for the intended purpose.

These eight people have been kept very busy with a number of charges that come in, sometimes from the Congress and sometimes from the public, that they have to run down. If we find anything that looks criminal or that requires investigation or an indictment or anything of that kind, we send it over to the Department of Justice. But we have to have this capability ourselves given the volume of work and the volume of dollars and contracts that runs through that office. It is a staggering amount.

Mr. MICHEL. So this request for additional people would be solely in this area of contract and grant awards?

Secretary WEINBERGER. Yes. The thing that bothers us most is that this hasn't been done before, and with this enormous volume of grants and contracts going out virtually unaudited and unchecked, that is a major worry.

Mr. CARLUCCI. May I clarify one point, Congressman Michel. The purpose is clearly as the Secretary has stated. This does not mean, however, where there is an accusation against a Federal employee that he may have improperly let a contract we do not investigate it. Indeed we do investigate it, and this is in the best interests of the employee because in the vast majority of cases he is cleared and no further action has to be taken. But in some cases, we have found very serious abuses that have been referred to the FBI. I think it is for the employee's protection as well.

The other day somebody made a charge against me, and I immediately picked up the phone to the inspection unit and I said I wanted that thoroughly checked out. That is protection for me, for the Secretary and for every other employee in HEW, and we should have that kind of protection.

Secretary WEINBERGER. In the kind of atmosphere that is prevalent today in Washington a lot of people think all you are doing is trying to spy on your employees or something of that kind. But when the public knows that we are dealing with $7 to $8 billion of grants a year with the possibility of either criminal activity or negligence amounting to that, I just don't feel very comfortable charged with the responsibility for those grants without having some people to run down charges and make sure that these things are being properly handled.

Mr. MICHEL. I would like to turn to a couple of questions in education.

Secretary WEINBERGER. Yes, sir.

REVENUE SHARING

Mr. MICHEL. While answering to my question on revenue sharing, I think you said that most of the money has been going in the field of education. Of course, under general revenue sharing local users are forbidden to allocate any of those general revenue-sharing funds for education, so they obviously must be getting all of that from the State. I believe about 65 percent of the State allocations alone in general revenue sharing have gone for education. That is all right.

Secretary WEINBERGER. You understand that the local unit can use it for construction, education, and capital improvement, but not educational operating funds. The State can use it for either one. Our figures show about 24 percent of the total allocated the first year went for education. That would be about $687 million out of the first $2.8 billion.

Mr. MICHEL. Would you, after consulting with your figures, whatever is available, put in the amount that actually did go for construction in the area from local funds?

Secretary WEINBERGER. If the Treasury breaks it down that far we will, yes, sir.

[The information follows:]

The Department of the Treasury reports that $2,817,900,000 was expended through general revenue sharing between January 1, 1972, and June 30, 1973. The amount expended for education for all units of Government was $687,200,000 of which $44,200,000 was for education capital expenditures. The county and city government share of this total was $21 million, all for capital expenditures.

UNCLAIMED BASIC EDUCATIONAL OPPORTUNITY GRANTS

Mr. MICHEL. The press seems to be concentrating most in two areas these days in the education area, on the student loan defaults and unclaimed basic opportunity grant money. The New York Times article a week ago headlined "Millions Unused in College Grants." It says you are having trouble giving away the money and are making grant awards retroactive to the start of the school year. Is this true?

Secretary WEINBERGER. We need to provide a little background on that, Congressman. We had recommended last year $1 billion basic educational opportunity grant program. Eventually after substantial delays, as I recall it, about May we got $122 million which enabled us to start the program for first-year students only.

We then had to get notices out to the schools, high schools and preparatory schools and so on that this fund was available but limited, contrary to our previous discussions, to first-year students and the amount would be a lot smaller than we had originally hoped

Of that $122 million we have already allocated $60 million and we will allocate about $30 million more of it by the end of May.

We have received 500,000 applications, and we have determined that about 55 percent or 280,000 are eligible. Since November the rate of applications has been running about 10,000 a week, or about 40,000 a month. We believe there is still not enough knowledge about the program available to students.

We had so many problems getting anybody's attention to this program that we had to do something I strongly deplore. We had to employ on a contract consulting basis a public relations firm to publicize the program because we could not get any space in the press. We had to try through that means to get notice to the schools and, through them, to the students, that students could apply.

The deadline for submitting applications has been extended to April 1, and we have continued to intensify our efforts to disseminate information about it.

We approved the new family contribution schedule by December 10. Last year we did not get it done until May because we did not get the appropriation until May. We are trying in every way we can to let the public know of this program because we regard it, obviously, as a very important part of our student aid assistance program.

We have asked the Congress for $1.3 billion. We want to extend it to all 4 years rather than just first-year students. We believe that this is, practically speaking, a Federal scholarship, and that it will have the success a lot of State scholarship programs have had in getting funds to deserving people.

It is a program which funds the individual, not the institution. It lets him make his own choice as to where he wants to go. It then means that he can go to the school of his choice if he can satisfy the admission requirements of the institution. We do not interfere with that in any way. It gives him the funds and could give him, if he got full funding, up to $1,400.

Mr. MICHEL. What is the average grant now?

Secretary WEINBERGER. A maximum of $400. I think the average grant is $300.

Mr. YOUNG. The first year, 1973, was $260. In 1974, it should be $475. In 1975, with the administration's proposal, it would be on the average $700 per individual.

Secretary WEINBERGER. The maximum is $1,400. We know this would require most students to get other forms of assistance, either from families or through scholarships or work.

But the President has said many times that this is a program he is personally interested in, and he does not feel that it is at all bad that the student must share in the cost of his education.

He also feels that he wanted a program that would enable us to say that, with the assistance we are providing and with some work by the student, no student would be deprived of a college education at the institution to which he could be admitted. He would not have to be deprived of an education for such an irrelevant reason as income.

STUDENT LOAN GUARANTEE PROGRAM

Mr. FLOOD. What about people who have to go out and borrow money?

Secretary WEINBERGER. We also have a middle-income people program, separate from this which involves a guaranteed loan in the form of either a subsidy or a deferment of the interest payment.

Mr. FLOOD. If he cannot borrow the money, he has to quit school.

Secretary WEINBERGER. The guaranteed loan program, we think, will make a substantial improvement in his chances of borrowing money. There have been some problems with it, I grant you. They have stemmed from the fact that we have required too much paperwork and have discouraged some banks and lending institutions from making loans.

We are trying to correct that now. We are trying to show lending institutions that we do take care of defaults very quickly, and that it is a program in which they ought to participate. We are trying to smooth the paperwork and shorten it so they do not have the problems involved in realizing on the guarantee.

We have both the program for the students who are without funds, very low income, the BEOG's program, and the guaranteed loan and the deferment of interest for the middle-income students.

We have legislation which is now pending, I believe, in the House Education Subcommittee.

Mr. CARLUCCI. It has been introduced by Congressman Quie.

Mr. MICHEL. I have heard something about the encouraging of the banks to be more liberal in their loans.

Secretary WEINBERGER. To reduce the paperwork and improve the procedures.

Mr. CARLUCCI. I might explain briefly.

Mr. MICHEL. You may expand for the record, but cover it briefly now.

Mr. Carlucci. First of all, we would up the total amount that a student could borrow from $10,000 to $25,000.

Secondly, we would eliminate the needs test as part of the process for receiving a guaranteed student loan. The reason for that, of course, is that many of the banks have been using the means test as a way of limiting the dispersal of loan funds in the aggregate. We would free them of the need to conduct a means test, but we would transfer the interest subsidy, so to speak, to the BEOG grant. That is, if he is a low-income student and can qualify for a BEOG grant, he could then add the interest on his guaranteed student loan to his BEOG grant. We would lift the 50-percent operating expenses limit by the amount of the interest charge.

In addition, we would raise the limit of the total grant, if necessary, to accommodate the interest.

We would also tighten up on some of the abuses in the program, such as not allowing students to claim they were not of the age of majority so they could default on the loans. We would allow the compounding of interest, if the student is in school and the principal payments are deferred. We would also provide a greater spread in the interest rate so the banker would have a larger margin within which to work. We would raise that interest limit up to 11 percent.

There is a series of measures we would take to try to make these loan funds more available.

[Additional comments submitted:]

In the area of higher education the 1975 budget reflects a continuation of the policy to emphasize student assistance programs. The policy will continue the major reforms authorized by the Education Amendments of 1972.

The request for $1.3 billion in the basic opportunity grant program will full-fund all 4 years. In addition to the request for $250 million for work-study, $11 million for cooperative education, and $315 for the guaranteed student loan program, there are several administration proposals that would improve the student loan program. They include:

> All loans would be unsubsidized. This would end the confusion which now exists in the minds of some lenders about eligibility for subsidy and eligibility for a loan.
>
> For students who have great need, interest payments incurred while in school on a federally insured loan would be provided through a dollar-for-dollar increase in the size of their basic educational opportunity grant.
>
> Lenders would be assured of a guaranteed rate of return on these loans which would take into account existing money market supply and demand conditions.
>
> Significant proposals are offered to tighten the administration of the program and to reduce the default rate.

Mr. Michel. I must say I was a little shocked during the course of that testimony to read that proposal extending the loan obligation from $10,000 to $25,000. How many do you have currently in that category that have already exceeded what they are eligible for at $10,000 and would really avail themselves of going into debt further?

Mr. Carlucci. We will supply what figures we have for the record, but the principal purpose in doing that is to accommodate graduate education, particularly in the health manpower area, people going to medical school, because this kind of approach has to be looked at in conjunction with our health manpower proposals. Certainly, someone who is going to medical school can afford a higher debt burden because the payback from that kind of investment is very good indeed.

[The information follows:]

Under the guaranteed student loan program and the national direct student loan program estimates show that approximately 7 percent of the students that borrow, borrow the maximum allowable. However, it is difficult to know how many of that number would avail themselves of additional aid if it were available. Because there are several ways that a student can complete an aid package, unless each student had been asked specifically if he would borrow more if it were available there would be no way to estimate the number that would have done so.

Mr. FLOOD. What about our 19-year-old specialists in bankruptcy? Have you checked that much lately?

Secretary WEINBERGER. We have had certain indications of how the program can be misused, Mr. Chairman, and we have also——

Mr. FLOOD. Is it a big deal?

Secretary WEINBERGER. There are not very many doing that.

Mr. CARLUCCI. We do have that covered in our legislative proposal Mr. Chairman.

Mr. MICHEL. We had a significant amount in the supplemental for loan default, to the extent some of us are getting pretty exercised about it, and I guess want to know for sure we are doing everything we can to hold these to a bare minimum.

Secretary WEINBERGER. Any guaranteed loan program will have this aspect.

Mr. FLOOD. What about all these 19-year-old specialists in bankruptcy?

Mr. CARLUCCI. They will be taken care of under our legislative proposal.

In addition, as this committee knows, we asked you in the supplemental for 250 additional positions to monitor the program. With those additional positions and with the legislative steps that we have proposed, we think we can both tighten up on the program and make the loan more readily available to the middle-income students.

Secretary WEINBERGER. I think the point the Under Secretary made with respect to the basic program being largely for college while the guaranteed loans include graduate school, is very important, because we have had questions as to how students in the graduate schools of health professions would finance their training. That is why we felt we had to raise it to $25,000.

The other thing in which you might be interested is that the basic educational opportunity grants program, the BEOG program, is not entirely limited to low-income families. Thirty-four percent of the first grant went to students from families with incomes over $9,000. Almost 11 percent went to families with incomes over $12,000. These are families with a number of children for whom the educational obligation is a very big one. We are not hitting only low-income students with that, although a very substantial number of low-income students are benefiting from it.

Mr. CARLUCCI. Finally, we are issuing a new set of regulations for this program, too.

IMPOUNDMENT

Mr. MICHEL. Mr. Secretary, do you or the administration have any overall policy on impoundment this year?

Secretary WEINBERGER. Except for the funds which the 1974 appropriations bill authorized to be withheld from spending, there are no impoundments that I am aware of in this Department nor do we have any plans to withhold funds as a method of achieving fiscal savings. Of course, we will not spend funds simply to keep them from lapsing. There must be meritorious projects to fund before we will spend money.

DECENTRALIZATION

Mr. Michel. Mr. Secretary, we have heard a lot about the so-called decentralization of HEW programs. Perhaps there has been more emotion about this subject than there has been information. It would be helpful if you defined what you mean by decentralization, also why you think there should be more movement of HEW programs to the field. And, you might review for us how you intend to deal with the Congress on this subject.

Secretary Weinberger. Decentralization is a delegation of program authority from a program official in Washington, such as the Commissioner of Education, to his counterpart in a region such as a Regional Commissioner of Education.

The Department's programs are being examined to determine the feasibility of decentralization. We believe firmly that in many cases decentralization will enhance our capabilities to serve more effectively the HEW constituencies and help to reduce the dependency of the citizens that we serve. Decentralization judgments are made on a case-by-case basis. We are proceeding at a pace which allows all affected parties to comment and participate in the decisionmaking. This includes the Congress.

COMPARABILITY

Mr. Michel. A requirement of the current title I ESEA program is "comparability," which, as I read it, means that a school district has to spend "comparable" State and local funds in all schools before adding the extra title I Federal compensatory money. Is this on target? Am I reading it right?

Now, as I understand it, on January 1 of this year States were to have told you which of their school districts have complied with this "comparability" rule, and you have set March 31 as a fund cut-off date for those districts which have not complied. Is this correct?

Where are you with this now? Will you enforce the cutoff, or is this up to the States? Have any districts been cut off? What happens when one is?

Secretary Weinberger. "Comparability" means that a school district must provide in title I schools ratios of pupils to instructional staff and amounts of State and local funds for instructional salaries—less seniority pay—in each title I project school that is comparable to the corresponding averages for nontitle I schools.

We are proceeding on target. On October 1, 1973, local school districts collected comparability data. They reported to their respective States by December 1, 1973. In turn, State agencies submitted reports to the Office of Education on January 1, 1974, showing the number of compliant local districts and the number of noncompliant districts whose title I funds were being withheld until they achieved comparability.

Federal regulations require that any local districts remaining out of compliance as of March 31 must have their title I applications finally disapproved by the State educational agency and must have their title I entitlements made available for reallocation to complying local school districts in the States.

In summary, it is up to the States to enforce the March 31 cut-off date. The State educational agencies will be reporting to the Office of Education on their comparability determinations through March 31 and will identify the local school districts whose applications were finally disapproved because of their failure to show that they were providing comparable services in their title I schools.

GRANT CONSOLIDATION AND FORWARD FUNDING

Mr. MICHEL. Mr. Secretary, you have proposed a supplemental which links consolidation of education grants with forward funding. How do you define the relationship between the two?

Secretary WEINBERGER. They are basically independent events, Mr. Michel, as either proposal could stand alone on its own merits—in fact during each of the past several years we have proposed major educational consolidations. We have proposed forward funding these programs because of the long lead time usually required to hire teachers and program other education funds. The school year is usually well underway before appropriations are enacted. We proposed the forward funding idea as a supplemental because legislation was required for most of the programs involved in the consolidation and we felt that our proposal would help to stimulate enactment of that legislation.

Mr. MICHEL. If you don't get consolidation, what happens to forward funding?

Secretary WEINBERGER. If the legislation is finalized too late for our proposed forward funding supplemental to be considered by the Congress in fiscal year 1974, we will have to reconsider whether to submit a 1975 supplemental for forward funding the 1975–76 academic year.

As you know Mr. Michel, Congress must take some action because most of the authorities covering over elementary and secondary education programs expire June 30 and there is no automatic 1-year extension. Thus, we cannot forward fund without some type of congressional action.

VOCATIONAL EDUCATION

Mr. MICHEL. If you don't get consolidation, what will your posture be on funding of vocational education in fiscal 1975?

Secretary WEINBERGER. If consolidation legislation for vocational education is not enacted, funds for 1975 will be requested under existing authorities as carried in the Vocational Education Act of 1973. As you know parts of the Vocational Education Act do not expire until the end of 1975.

COST OF REGIONALIZATION

Mr. MICHEL. What is regionalization costing in S. & E. money in the Office of Education?

Secretary WEINBERGER. During fiscal year 1974 initial planning for decentralization for selected OE programs was begun. In anticipation of executing an approved plan during fiscal year 1974 funds were set aside ($936,000) in the Office of Education's salaries and expenses appropriation operating plan. However, current plans do not provide for any regionalization of OE programs during fiscal year 1974. Further planning will, of course, take into consideration the consolidated education grants proposed for fiscal year 1975.

INCREASE IN SALARIES AND EXPENSES, OFFICE OF EDUCATION

Mr. MICHEL. The budget for elementary and secondary education activities is about the same as last year, yet USOE salaries and expenses appear to jump about 25 percent. How do you account for this?

Secretary WEINBERGER. Of the $23,649,000 requested increase in this appropriation, only $15,023,000 is associated with the program administration activity. The remainder of the net requested increase, $8,626,000, is for activities unrelated to program administration: planning and evaluation, $1,781,000; general program dissemination, $4 million, data systems improvement, $2,850,000, and rent payments to GSA, $3,953,000. The increase that is requested for program administration is made up mainly of built-in increases to cover annualized costs for positions authorized in 1974. The only major program increase requested for program administration is to support additional ADP requirements to improve management of the guaranteed student loan program. The request represents a net decrease of 114 positions.

SEPARATE COMMITTEE ON EDUCATION

Mr. MICHEL. Have you ever been asked by anyone up here—I mean for a formal opinion—on whether there should be a separate Committee on Education in the House? Do you care to comment?

Secretary WEINBERGER. This is an area which it seems to me is up to the Congress to decide. I am aware that a couple of years ago the Congress broke education out of the bill and passed it in advance of the rest of the Labor-HEW appropriations. This was done, I understand, to get the funds out to the schools before the start of the school year. However, our proposal to forward fund the elementary and secondary programs makes the need for a separate bill less pressing.

MANAGEMENT OF GUARANTEED STUDENT LOAN PROGRAM

Mr. MICHEL. Mr. Secretary, you have just recently made a decision to place the responsibility for the management of all related guaranteed student loan program functions under the aegis of the Deputy Commissioner for Management in the Office of Education. Would you provide for the record some explanation of the factors that led to this decision.

Secretary WEINBERGER. As I explained in a letter to the Comptroller General in January, there exists a pressing need to strengthen the performance of the guaranteed student loan program through improved management and the provision of increased resources. The latter point has been addressed in budget justifications for both the fiscal year 1974 supplemental request and the fiscal year 1975 request.

In addition, I directed that all of the functions related to the guaranteed student loan program be pulled together on a project basis, and that the manager of the program report directly to the Deputy Commissioner for Management. This has already led to the formation of an Office of Guaranteed Student Loans which has it own ADP systems capability and all the other resources necessary to function independently of the service and support function generally provided for the Office of Education program administration.

The sheer magnitude of this program, which may command as much as one-sixth of all the Office of Education personnel in fiscal year 1975, requires that it be given the highest level of management direction and support.

Only in this way will we be able to improve collection efforts, speed transactions with lenders, and expand the number of potential sources of funds while simultaneously exerting proper and timely monitoring procedures.

WASHINGTON INTERNSHIP IN EDUCATION

Mr. MICHEL. I understand that the Washington internships in education program is being funded solely by the Ford Foundation in 1973–74. Is this correct? I believe this activity was initiated in 1964 by the Ford Foundation and was, of course, subsequently funded for several years by USOE grants under the Educational Professions Development Act as well as by the Ford Foundation. In these days with all the fiscal pressures on all our programs, isn't it more appropriate for activities like this to be funded solely by outside sources such as Ford, rather than through tax dollars?

Secretary WEINBERGER. In the past the Washington internships in education program was partially funded by U.S. Office of Education grants. In fiscal year 1973, it was determined that the Department should not fund the WIE program from Office of Education program moneys. However, nine interns were on board under the old program. In order to avoid a hardship on the interns, and to discharge the Federal obligation, it was determined that their salaries would be funded from salary and expense moneys under the authority of title IV of the Intergovernmental Personnel Act to complete the fiscal year 1973 period of their assignment. The Department therefore reimbursed George Washington University, the "parent" organization for the Washington internships in education program, for a percentage of each Intern's salary expenses.

In fiscal year 1974, WIE's are treated as temporary employees while on assignment with the Department. By receiving 9-month temporary appointments under existing temporary hiring authorities, the Department is providing three-fourths of the cost of salaries for the 1-year internships. This is in direct proportion to the services the Department receives from the interns; that is, three-fourths of the internship is spent in a working situation and one-fourth of the time is devoted to special developmental activities. While the Department provides a unique learning environment for these potential leaders in American education, at the same time it profits immensely from the background, experience, and motivation the interns bring to their assignments.

Mr. MICHEL. Is there anything in your 1975 budget for support of WIE?

Secretary WEINBERGER. In fiscal year 1975, WIE's serving in our Department will again receive 9-month temporary appointments. These salaries will be our only funding commitment to the Washington internships in education program.

HEALTH STAFF SEMINAR

Mr. Michel. Are you aware that the Institute for Educational Leadership at George Washington University which sponsors the WIE program is also sponsoring a Carnegie-funded health staff seminar for which Federal funds are also being sought? Have any decisions been made within your department on this? From what Department of Health, Education, and Welfare account would such funding come? Is this an appropriate activity for Federal funding?

Secretary Weinberger. I am not aware of a request for Federal funding for those seminars. This is something that I will have to get more information on and provide for the record.

[The information referred to follows:]

Federal funding of the health staff seminars has not been requested, nor are there current plans by the organization conducting the seminars to request Federal financing.

THE 1975 BUDGET TOTALS

Mr. Natcher. Mr. Secretary, as you pointed out to the committee in your general statement, the overall amount requested is $111 billion, which is an increase of $14.3 billion over the current fiscal year 1974.

Secretary Weinberger. Yes, sir.

Mr. Natcher. This then, of course, makes this the largest appropriation bill in the budget. I believe that is correct, is it not?

Secretary Weinberger. It certainly is the largest financed department in the Government. I believe the bill is also the largest.

Mr. Natcher. This, of course, includes the trust fund money.

Secretary Weinberger. Yes, sir.

Mr. Natcher. You have also advised the committee that 94 percent of your entire amount is in the grant fund category.

Secretary Weinberger. It is in the uncontrollable category in the sense that we cannot make reductions in it because it is fixed by formulas in the statutes, and so on.

Mr. Natcher. That would include all of your grant money?

Secretary Weinberger. No. I do not think it includes all the grant money. It includes the social security, medicare, medicaid, supplementary security, all the trust fund programs, some of the health programs, but it does not include all of the grants, because there is a controllable feature in the sense that less could be appropriated for them.

Mr. Natcher. It is not regular formula money.

Secretary Weinberger. No.

PROGRAM EVALUATION

Mr. Natcher. From time to time during the past few years, we have had requests in the budget for Health, Education, and Welfare for program evaluation.

Secretary Weinberger. Yes, sir.

Mr. Natcher. Do we have throughout this budget amounts for program evaluation?

Secretary Weinberger. We do.

Mr. NATCHER. Can you give me some idea as to the total amount involved?

Secretary WEINBERGER. $60,624,000 for evaluation is requested specifically in the 1975 budget. This is spread about $40 million in the health area, about $11.9 million in the education area, $3.3 million in the social and rehabilitative services, and $5.1 million in the Office of Human Development, including juvenile delinquency, aging, and child development.

Mr. NATCHER. With your permission, I would like to have that inserted in the record at this point.

[The information follows:]

EVALUATION FUNDS AVAILABLE [1]—FISCAL YEAR 1973–75

[In thousands of dollars]

Agency/appropriation	Fiscal year— 1973	1974	1975
CDC	1,601	1,345	1,378
HSA	9,867	7,975	7,824
NIH	17,625	17,482	18,349
ADAMHA	8,037	7,930	6,922
HRA	12,421	11,136	5,739
Subtotal, health	[2] 49,551	45,868	40,212
Follow Through [3]	4,246	3,394	2,900
Emergency school aid [3]	3,280	2,489	
Salaries and expenses	10,205	5,205	9,000
Subtotal, education	17,731	11,088	11,900
WIN [3]	1,800	1,800	1,800
Rehabilitation	1,000	1,000	1,000
Developmental disabilities	445	411	536
Subtotal, SRS	3,245	3,211	3,336
OCD	3,000	3,000	3,000
Juvenile delinquency	100	100	150
Aging	956	2,956	2,026
Subtotal, OHD	4,056	6,056	5,176
Total, DHEW	74,583	66,223	60,624

[1] Includes funds available to the Office of the Secretary—Assistant Secretary for Planning and Evaluation.

[2] Only $14,743,000 was actually obligated in fiscal year 1973.

[3] No funds available for Assistant Secretary for Planning and Evaluation.

Mr. NATCHER. Mr. Secretary, under your program evaluation that we have had in the past, do you find this program generally pays dividends? Is it successful? Do you obtain new ideas? Do you also obtain information from the standpoint of changing programs, saving money, and making changes generally throughout the Department that are beneficial?

Secretary WEINBERGER. I will give you a qualified answer, Congressman Natcher. I believe we get considerable benefit out of evaluation. I believe we could get considerably more than we do. I am not entirely satisfied with the evaluation effort here any more than with the evaluation effort at the Office of Management and Budget when I was there.

The basic question I want to know when I ask about these things is: Is this program working? Who is it benefiting? Is it doing what the Congress wanted it to do? What are we getting out of it?

I like to get answers to that to enable us to help choose our priorities for next year's appropriations. It frequently is very difficult, particularly in the social field, to get answers of a specific nature on programs of this type. I believe we can do better than we have.

On the other hand, we do have some answers which are very specific. The frustrating thing about those is that frequently, on the basis of that evaluation, we can advise you with very little qualification that a program is either not working or has worked well but is now finished. We then make recommendations with respect to terminating it, but those recommendations normally are not followed.

We do have a continuing effort in this field because I think it is one of the most important things we are doing. I do not like to come before you and ask that we simply increase each program that we had last year by the amount of inflation or whatever. I would like to be able to tell you that what we need is this, and what we do not need is that, and that that should be our budget.

We have done that again this year. We have recommended on the basis of our evaluation that some programs be terminated, and others be reduced.

I still am not satisfied that the evaluation effort is doing all it should. We do have a substantial sum in the budget, and we are continually working to try to improve it.

HEW AUDIT STAFF

Mr. NATCHER. Going back to one of my chairman's questions in regard to audit, I believe at the present time you have 893 auditors. Is that correct?

Secretary WEINBERGER. I think that is roughly correct.

Mr. YOUNG. This is correct, and today all but 22 of the positions are filled.

Mr. NATCHER. Under financial management is where you have your auditing positions. This certainly would be an adequate number, would it not, Mr. Secretary?

Secretary WEINBERGER. I think in the audit field, that is correct. Mr. Young, our Comptroller, might want to go into detail on that.

Mr. NATCHER. You certainly would not ask for any more, Mr. Young?

Mr. YOUNG. That is a judgment call. That is like Internal Revenue Service collectors, auditors and intelligence agents. At the present time we have requests for priority audit over and above the 850 professional auditors we have, of approximately 500 man-years of requests for audit.

Mr. NATCHER. Do you have a request before this committee at this time for additional auditors?

Mr. YOUNG. We have a request before this committee for 18.

Mr. NATCHER. In addition to the 893 now aboard?

Mr. YOUNG. Yes, sir.

BUDGET FOR NATIONAL DEFENSE

Mr. NATCHER. Mr. Secretary, I want to thank you for your statement before this committee. You recall at your last appearance on the bill for fiscal year 1974, you and I discussed generally the type of statement that you had prepared for the committee, comparing some of your reductions with the need for Defense money stating in your statement generally the necessity for huge amounts as far as Defense.

You recall, Mr. Secretary, I disagreed with you a little bit about it. In fact, the statement ahead of your statement, for the year before, contained almost the same paragraph.

Mr. Secretary, I want to commend you for leaving it out this time. This is your second regular appearance before the committee.

Secretary Weinberger. Yes, sir.

Mr. Natcher. As one member of the committee, I do not believe that peace costs more than war. I say that to you frankly. I know and you know that certainly as far as the security of this country is concerned, we must have a country that is secure. There is no question about that. But I want to commend you on the type of statement that you made before the committee this time. Mr. Secretary, you made a good statement.

Secretary Weinberger. Thank you very much, sir.

In extenuation, may I say I had been here only 2 weeks last time when I appeared before you.

On the Defense budget, I do feel we have a very substantial problem in that the increases that are requested are not going to increase materially the strength of the defense. They are going mostly for pay increases. That is, of course, a worry.

Mr. Flood. Mr. Robinson.

NEW POSITIONS FOR SUPPLEMENTAL SECURITY INCOME PROGRAM

Mr. Robinson. Mr. Secretary, you are requesting the addition of 12,000 more people than you have in your Department at the present time, which is an increase of just about 10 percent, a huge increase. I am sure you realize that as much as I.

You say that 11,000 of those are going to be required to administer the new SSI program.

Secretary Weinberger. Yes, sir.

Mr. Robinson. How many of those people would be located in the regional and other offices, and how many of them in Washington?

Secretary Weinberger. I would have to get that, and I can get it from the Social Security Administrator. I would be guessing. Somebody else here may want to try it, but we will supply it for you.

[The information follows:]

As the following table shows, 6,000 of the additional 11,000 positions for SSA represent the increase in positions required by the SSI program between fiscal year 1973 and fiscal year 1975.

SSA EMPLOYMENT—END OF YEAR CEILING

	Fiscal year—			Change fiscal year 1975 over fiscal year 1973
	1973 actual	1974	1975	
SSA Total (permanent)	61, 204	71, 665	72, 365	+11, 161
Headquarters	(19, 959)	(22, 215)	(22, 430)	
Field	(41, 245)	(49, 450)	(49, 935)	
SSI included in above	8, 505	14, 550	14, 625	+6, 120
Headquarters	(2, 637)	(4, 511)	(4, 538)	
Field	(5, 868)	(10, 039)	(10, 087)	

Secretary **WEINBERGER.** If I might point out one thing in connection with this, we took over this program from the State governments and the county governments, as you know, at the direction of the Congress; 32,000 people were employed by State and local governments to do this work.

We are now, as we say, at about 11,000, and with some of the people we had roughly in the 13,000–14,000 category. That is all I want to ask for.

That would mean we would be doing this program with half the people that the State and local governments required for it when it was a State program. I think that is an indication of the fact that the 11,000 requested in that area is a reasonable request.

It is a sore and bitter pill to me to have to ask for that many more. I would rather have told you we were doing all our work with 10,000 less people.

Mr. **ROBINSON.** Knowing that number of people was employed in the State program, this was to be my next question: How many more than the additional 11,000 do you think it will take?

Secretary **WEINBERGER.** I do not believe it will take any more. This is the fiscal year 1975 request, and we believe that will be the ongoing number that will be required.

That will mean that we are running approximately 13,000–14,000 people total in the program when it is fully geared up as a Federal program.

Mr. **ROBINSON.** I do not have to tell you, so often we have seen these agencies burgeon as far as their employment is concerned. We have to look at this very carefully in terms of personnel numbers.

Secretary **WEINBERGER.** The problem is that we took over a program that had 3.2 million beneficiaries, and the Congress enlarged the eligibility. We now have the possibility of 6 million beneficiaries from this program as opposed to the 3.2 million. When we do the job with half the people, it will be a job that might be twice as big.

PSRO

Mr. **ROBINSON.** I now want to turn our attention to PSRO, Mr. Secretary.

I know you are aware of the objection from the medical profession in my State of Virginia to your plan for a five-region setup which was appealed. On basis of a letter I have from you dated March 13 you state that in the Federal Register of about March 18, the request will be denied, and that the same five regions will be established in Virginia.

In spite of that, in your testimony you say this is a program which you want to see run by physicians with support and assistance by the Government.

Secretary **WEINBERGER.** I did not mean to say I wanted to see that, Congressman. I meant to say that is what the law requires, and that we are going to carry out the law as long as it is on the books.

Mr. **ROBINSON.** You also said that it can cause, in your view, substantial interference with the practice of medicine as we have known it before, and that you also—I think this is an accurate quote—made all the changes that you possibly could with regard to trying to accommodate the medical profession in the various States.

Secretary Weinberger. And the various people who sent in objections in addition to the medical profession. Yes, sir, that is a correct statement. We did.

Mr. Robinson. My question is: Since this is an effort to try to operate these PSRO's as closely as possible on a State level, to what extent were the various medical societies in the States consulted with regard to the way they thought it would work best within their State, because time and time again you have mentioned that you want to work with the States?

Secretary Weinberger. We do. However, we have guidelines in the statute which we attempted to carry out with regulations that bind us and prevent us from simply saying that we will do in each State what each State medical society would like. We did try to accommodate all of those views to the greatest extent that we felt the statute would allow us, and we did get, as the Under Secretary has stated, something like half the States with a single State PSRO.

We were not able to do that with Virginia. We were not able to do it with Texas or Illinois or many States with very widely diverse circumstances of medical practice within the State, and where various other conditions that were set forth in the statutory guidelines would not be satisfied by a single State PSRO.

I would infinitely have preferred to do it wherever we possibly could and to do it in all cases, because, for one thing, it would have eliminated a lot of mail. But we simply felt we had to go along with the statutory boundary lines and guidelines. If those were to be changed, I would have no hesitancy in changing the designation, but we were bound by the statute adopted in October 1972.

Certainly varying interpretations of that statute could be made. We tried to carry out as best we could the intention of the Congress.

Mr. Robinson. My concern is that in my State the premier advocate of PSRO has now been alienated to the extent he is on the other side of the fence. Now he is against the whole principle and this is going to constitute a substantial roadblock as far as getting the program underway.

Secretary Weinberger. It certainly would, because I think, as I have said before, that it is going to work well only if the doctors themselves do want to participate in it. That is what the statute contemplates. That is certainly what we tried to do.

All I can say is that we had no interest whatever in going against the wishes of each State. We did have to follow the statutory boundary lines. Wherever we could, we complied with the wishes as expressed to us by the various groups in the States, but there were some where it was reported to me we simply could not do it.

Though we did make many changes, as you know, between December and March, there weer some we just could not do.

As I mentioned to the chairman earlier this morning, it has many of the aspects of a congressional reapportionment nationwide. I never heard of one of those even statewide that left everybody satisfied.

Mr. Robinson. Since Virginia was one of those States in which no change was made whatsoever, but stays exactly as originally proposed, for the record I wish you would cite the statutory reasoning as to why it was that no change could be made in that instance or, indeed, in the instance of other States.

Secretary Weinberger. All right. With the chairman's permission, I will insert a statement which sums up why that particular result was reached with Virginia.

Mr. Flood. Without objection.

[The information follows:]

PSRO Area Designation Statement for Virginia

Section 1152(a) of Public Law 92-603 required the Secretary of HEW to establish throughout the United States "appropriate areas with respect to which professional standards review organizations may be designated . . ." The statute does not address specifically the optimum size or physician population of a PSRO area, but the report of the Senate Committee on Finance (Rept. 92-1230), September 26, 1972) does provide guidance on this question.

For example, the committee report states that ". . . in smaller or more sparsely populated States, the designations would probably be on a statewide basis. Each area, defined in geographic and medical service area terms, would generally include a minimum of 300 practicing physicians—in most cases substantially more than that number. Because of the minimum number of physicians required—intended to assure broad, diverse, and objective representation—it is expected that there will be many multicounty PSRO areas."

Further, the report makes repeated references to the level at which it is expected that professional standards review will take place and to the level at which it expects the responsibility for that review to reside:

> "Peer review should be performed at the local level * * *. The committee would stress that physicians—preferably through organizations sponsored by their local associations—should assume responsibility for the professional review activities * * *. Priority in designation as a PSRO would be given to organizations established at local levels * * *. Local sponsorship and operation should help engender confidence in the familiarity of the review group with the norms of medical practice in the area * * *".

Guidelines for implementing the above intent were developed and the key items in those guidelines are:

> A PSRO area should generally include a minimum of approximately 300 licensed, practicing physicians. While the maximum can be expected to vary with local circumstances, generally it should not exceed 2,500 licensed, practicing physicians.
>
> A PSRO area should, to the extent possible, coincide with a medical service area and assure broad, diverse representation of all medical specialties.
>
> Existing boundaries of current medical review organizations should be considered.

Given the above, Virginia does not reasonably qualify for a statewide PSRO. Virginia has over 5,000 physicians, there is a wide geographical area to cover, and there are distinct medical service areas in the State. Accordingly, five PSRO areas, based on the Medical Society's subdistricts and slightly modified to conform more closely with the Governor's State planning districts, were designated in Virginia.

GUARANTEED STUDENT LOAN

Mr. Robinson. Regarding the guaranteed student loan, you mentioned a tightening up and the additional positions that you want.

When the supplemental was before us for consideration and we went into this matter of the student loans, we were told that there was no credit risk factor involved in the consideration of a given individual for a certain loan.

Is this tightening up process in terms of your proposed legislation going to take any credit risk factor into consideration?

Secretary Weinberger. I do not believe so.

Mr. Carlucci. No. I am not sure what you contemplate by the use of that term.

Mr. Robinson. It was not my term.

Mr. Carlucci. I understand that.

In the sense that the loan is fully guaranteed, there presumably is no risk for the banker. We asked for 250 positions so we could tighten up on the program. The real problem has been in getting the bankers to take the risk, and give them sufficient incentive to process the paper.

This gets to the heart of the issue raised earlier of the middle-income student, because he is the one who has been falling out in the process.

Secretary **Weinberger**. Our Comptroller advises me that the statute uses the term "noncollateral loan."

Mr. **Young**. That is the implication.

Mr. **Robinson**. It is my feeling, even though they are noncollateral loans, there are good and bad risks, and there should be a credit risk factor with regard to making such loans.

Secretary **Weinberger**. The loan the lending institution makes is one issue. Our guarantee is to encourage them to make the loan. I do not think we would have any authority for a regulation which required them to look into the risk factors. We certainly try to encourage them to make the loans by reducing the paperwork necessary for them to collect. We would certainly try, once the default has occurred, to collect it for the taxpayers. That is one of the reasons for the extra people.

NATIONAL INSTITUTE OF EDUCATION

Mr. **Robinson**. One final question which has to do with the National Institute of Education.

When they were before us for the supplemental, I think the majority of the members of this committee felt that they did not make a good presentation or a good justification.

I wondered if, for the record, you would not like to enlarge on your advocacy of that particular institute.

Secretary **Weinberger**. Yes, sir. We will do that in a formal way.

I would say at this time that we believe there is a tremendous need to know if there are not some improved teaching methods, if there are not some improved factors that go into the learning process if there are not some novel and better types of curriculum and teaching aids.

We are trying to fund a research program to help develop our knowledge in this field on the theory that individual school districts or States would find this kind of research too expensive, but if we do it on a national basis we would be able to disseminate any results that we received and be of substantial help.

The National Council, as you know, sets the priorities in this field. Essentially, the five priority areas are to: provide essential skills for all individuals, with special emphasis on reading; improve the productivity of resources in the educational system; understand and improve the relationship between education and work; develop the problem-solving capacity in the State and local education systems and enable them, even in rural communities, to make educational changes; and increase the diversity in American education, including such things as the voucher experiment and others.

These are the basic priorities the Council has set for the Institute.

We believe that the funding requested of $130 million would enable us to get some reasonably significant results in these very important areas.

Mr. ROBINSON. Is it not true that most of these areas are being researched anyway, and that the problem is in getting the results of the grants and the various other types of funding in the research area into the hands of the educators?

Secretary WEINBERGER. That is always a problem with all grants and all Federal work. I cannot tell you it has been done as well as I would like to do it in any field. That certainly would be a problem with NIE.

We do think some of the activities that we would fund under NIE would be different from those that are funded under other existing programs. We do feel there is a necessity for it. It has been a high Presidential priority. We have asked for $130 million and also that the supplemental be granted to enable NIE to keep going and not cut back on some of their ongoing work.

Mr. ROBINSON. Because of the way you state it, in terms of priorities, gives me added reason to feel that its justification needs to be expanded in the record, because I do not think it has been established to a degree that indicates it is highly significant.

Secretary WEINBERGER. I think that is evident in the results that have come out so far. We would welcome that opportunity, Congressman.

[The information follows:]

HEW ADVOCACY OF NIE

In elaborating on the reasons that we feel that the National Institute of Education merits continuing and enlarged support, we might proceed by citing examples of some of the things NIE and its predecessor have in fact accomplished.

Eight or 10 years ago, it was perceived that few curriculum materials existed for the ever-increasing number of kindergarteners across the country. In particular, the quality of the materials available for introducing readings and other basic skills to these youngsters was not satisfactory to practitioners. Sponsored by the Office of Education and now NIE, the Southwest Regional Laboratory in the Los Angeles area systematically developed such materials. The development proceeded from analysis to testing, revising and retesting, to commercial publication. The materials now are used by 150,000 youngsters. This development effort produced a quality of materials that is higher than otherwise would have existed, since they are based on an understanding of learning processes validated by research, rather than solely on a textbook author's intuition.

In another area, the Wisconsin Research and Development Center relied heavily upon expertise from the University of Wisconsin to develop curricula which help teachers meet individual needs of students—the popular concept of individualized instruction. These materials, under the general title of individually guided instruction, were developed and tested in Wisconsin with the aid of the State education agency and many local education agencies. The reading materials alone now are used in about 3,400 schools by 2 million children across the country. Further, the laboratory's experience with these materials suggested the need for a new form of school reorganization and management; a need now fulfilled by a a multiunit school concept. This concept has been adopted by about 1,700 schools, serving 1 million students, across the country with the aid of the Office of Education and NIE.

NIE is responding to other demands for information by continuing and strengthening State dissemination programs. Local school systems increasingly turn to the chief State school officer for information about research or promising practices that can be used to improve local education. State departments of education, with OE and now NIE help, are developing the capacity to provide such assistance to schools. The primary information source for these State systems is Eric, a computerized system that collects information about education research and practice throughout the country. As an indication of the demand for this type of service, some 14 million Eric documents were sold to educators, students, and others in 1973. NIE also publishes reports that synthesize and translate research findings into terms understandable by parents, teachers, and administrators. These reports are circulated to public libraries throughout the country. In addition, the Government Printing Office has sold hundreds of copies; one of the most popular, for example, which describes environmental education programs has been purchased by 2,000 individuals and organizations. NIE's supplemental and fiscal year 1975 appropriation requests contain funds to improve the Eric system to make it even more accessible and relevant to users' needs and to continue to strengthen State departments' capacities to respond to local information needs.

NIE's five priority areas were selected with an eye to making future research and development activities even more relevant to the needs and concerns of educators, policymakers, and parents. In the reading area, for example, there now exists no coordinated leadership for studies of literacy problems. As a result of the past scattergun approach a great deal is known about early reading problems; very little about the middle grades. NIE's systematic focus on reading will emphasize the problems faced by fourth through eighth graders, the age where comprehension, and not simple translation of letters into sounds, is most critical. If NIE is successful, major breakthroughs in the teaching of reading in the middle grades can be expected in 3 to 4 years.

These examples, of course, are simply illustrative of what education research and development can do. First each of these activities has been carried out from a national perspective: the results have implications for all schoolchildren, not just those in one classroom or district. Second, they have resulted from the opportunity to bring together resources that no single district could command—NIE's fiscal 1975 budget request, for example, distributed among all the schools in the country would allow each to hire less than one-half a beginning teacher. Third, the Federal perspective is comprehensive, coordinating, and building on the work of researchers and practitioners across the country so that we do not reinvent the wheel nor experiment through costly trial-and-error methods. Finally, NIE's efforts build on the scientific methodologies that have led to major advances in medicine, agriculture, and space technology.

The quality of American education can be significantly improved—as it has in the past—by the gradual increase of research and development funds for the National Institute of Education. These results will not be obvious overnight, but, on the basis of our past experience, we feel strongly that this investment in NIE is an investment in the quality of American education in the future.

Mr. FLOOD. Mr. Smith.

ELEMENTARY AND SECONDARY EDUCATION ACT

Mr. SMITH. As you are aware, Mr. Secretary, we are currently working on the Elementary and Secondary Education Act.

Secretary WEINBERGER. Yes.

Mr. SMITH. It should have passed last fall. Nevertheless, it is still pending.

I believe you said this morning that the Senate bill is unacceptable to the President. I take it that is jargon which means it will be vetoed by the President.

What is wrong with it?

Secretary WEINBERGER. Mr. Carlucci expanded in considerable detail on that this morning, and I will be glad to ask him to do that again.

Mr. CARLUCCI. In the first place, the Senate bill creates some 15 new organizational entities in the Office of Education, many of which we think are not needed or are totally irrelevant to the purposes of the bills.

Secondly, there is no real consolidation of categorical programs in the Senate bill. The consolidation takes place only, under the provisions of S. 1539, after the categorical programs are fully funded, and then only in the amount of 50 cents on the dollar.

Next, there are provisions that would require us in the consolidation area to get advance approval from an authorizing committee before funding particular grants and contracts.

Finally, although there is some retrenchment in the phaseout of categories A and B of impact aid, they force the funding category C through the authorization mechanism. So, we are going in the wrong way in the impact aid issue.

Mr. SMITH. I also understood you to say that you had worked out some kind of agreement on the House side with the authorizing committee.

Mr. CARLUCCI. That is correct.

Mr. SMITH. That bill does not change category B impact aid, does it?

Mr. CARLUCCI. It extends the category B impact aid for 1 year. We would prefer a phaseout.

Mr. SMITH. I remember 3 years ago we discussed this in this same committee prior to the authorization being passed. I think the committee generally has supported the administration's point of view on category B versus A, but the authorization bill passed, and with hardly a whimper, and the President signed it. He vetoed a lot of bills, but he did not mind signing that one without saying very much.

It seems to me if you really are supporting phasing out category B, you would do something about it at the time of authorization.

Secretary WEINBERGER. We would like very much to. The problem is, we are running down to a very narrow time limit. On June 30, many authorizations on Federal aid to education run out. We would like very much to have the bill adopted in time so we could put our forward funding supplemental before you and notify the school districts thereby of how much they were going to get a year ahead, to enable them to do their planning.

The problem with category B was that it was included in the total appropriation bill that really did not offer the President very many opportunities to veto it. He has been against it ever since he was a freshman Congressman, and he is quite consistent in his feeling it is not a proper way to allocate Federal funds to education.

Mr. SMITH. I think you will agree that diverting $600 million or $800 million for this purpose does not add money to the total education budget of the country. It just diverts it under a different formula than otherwise would be used.

Secretary WEINBERGER. And in an area where the need is not established.

Mr. SMITH. You are really saying that your opposition to that kind of diversion is not as great as your support for your ideas of consolidation.

Mr. CARLUCCI. May I clarify that. We had a very long period of negotiation with the House committee on this bill. I think the record is replete with statements of our opposition to the category B funding.

As the Secretary indicated earlier, we did make some compromises in an effort to get a bill that was acceptable to both parties.

Our position on the impact aid category B is that we still would like to phase it out. We have $40 million in the budget to phase it out. Certainly, if an amendment to that effect should carry on the floor, we would be very happy indeed. But we have to weigh our opposition to impact aid B against the need to get some kind of education legislation.

Mr. SMITH. Apparently, to spend $600 million or $800 million that way is not objectionable enough to cause a veto, but if they do not consolidate the way you want to in the Senate, that would result in a veto.

Mr. Carlucci. I indicated the Senate continues impact aid as well, and adds category C to it. Our opposition is to category B funding, which I believe is in the neighborhood of $300 million.

Secretary Weinberger. Frequently, with the situation the way it is, we have to take the least of many objectionable alternatives. If the Appropriations Committee did not wish to appropriate the amount necessary to carry out impacted aid, I would personally welcome that action.

Mr. Smith. Compared to 4 years ago, we have really made progress on impact aid. Four years ago category B was 90 percent of maximum eligibility. It is now about 63 percent. The committee did come out two or three times in direct opposition to category B. There has been an educational process going forward. I think there is more support for this position now. That is what makes it even more disappointing to me that you do not put reform of category B at a higher priority in determining what is sufficient to cause a veto.

Secretary Weinberger. It is a very close call, and maybe the answer is that I am wrong to be reasonable this year.

Mr. Flood. Mr. Casey.

PSRO

Mr. Casey. Mr. Secretary, I have some questions on PSRO.

As you well know, those in the medical profession in Texas are very unhappy.

Secretary Weinberger. Yes, sir.

Mr. Casey. They are of the opinion—and I share their opinion—that there is nothing which prohibits you from designating a statewide review organization.

Under their terms, they were proposing a statewide organization which, you will recall, is made up of not just the MD's but also the osteopaths and the hospitals. They had proposed an organization in which they would try to work out their differences and jealousies, the Texas Medical Institute. They proposed to submit to you designated areas that would report to the central office.

You have testified here today that they could have a support center which would do the computer work and provide other centralized services. It sounds almost like the version they submitted to you, except that you designated the eight particular geographical areas.

Secretary Weinberger. The fact that eight areas are designated simply means that there would have to be a PSRO organiaztion within each of those eight areas. The fact that there could be a statewide central support unit means, first of all, the administrative services, computer work, overhead, and so on, could be performed at the statewide level, and it also means that a substantial number of policies involved in administration which do get into programmatic operations could be set at the State level.

We would be glad to put in the record the same kind of statement for Texas we are going to do at Congressman Robinson's suggestion for Virginia, as to what it was in the law that we felt prevented us from authorizing a single State PSRO for the whole State of Texas.

Mr. Casey. You might do that. It might be helpful to you, but I doubt it.

Secretary Weinberger. As I said to Congressman Robinson, I would infinitely have preferred to follow a course that would not have generated a lot of opposition.

With many States we had situations where more PSRO's were desired than we felt we needed to grant. In some—Texas was certainly one—a single State one was desired, and we felt the law prevented our going along with that.

It is the dimensions of the law, not anything else, which required that decision. Should a change in the law be considered, obviously there would be no opposition from me to a change of that kind.

Mr. CASEY. With reference to changing the law, you stated earlier to the chairman that this particular section of the law setting up the PSRO's was not requested by the administration.

Secretary WEINBERGER. That is correct.

Mr. CASEY. It was pointed out that we in the House did not know anything about it until the roof caved in on us, because it was put in by the conference committee.

We were all concerned with the major portion of the bill, and we did not realize the change had been made until later.

You have also expressed some concern that it could be an interference of Government in the practice of medicine which was not deserved.

Secretary WEINBERGER. I think that is right. I think that, under the law, a Federal agency is charged with the general, overall administration of the program designed by people who preferred to have the Federal Government operate the medical profession. There is a real danger. I feel very strongly the other way, but I obviously feel that we must plan to carry out the intention of the law.

I think the intention of the law is that the physicians operate it if they wish to do so. There is a direction in the law that we operate it if the physicians do not wish to do it. We are trying to insure that it is operated in a way that preserves the very high quality of medical care that I think America has been fortunate in having as a result of the private system.

Mr. CASEY. You say they asked for particular laws and acts. Since you did not ask for this one, and you do have some concern about the extent of it, have you or any part of the executive department asked for an amendment of this act?

Secretary WEINBERGER. No; I think we can administer the law as it stands, but there are administrative philosophies that are important to bear in mind.

I simply point out my feeling that there are other ways in which this law could be administered that I think would be quite undesirable. I was trying to point out to the committee that the basic philosophy with which we approach it is, I think, the same as that with which Senator Bennett approached it when he proposed the amendment in the Senate.

PEER REVIEW SYSTEM

Mr. CASEY. Earlier, in response to the chairman, you expressed confidence in the peer review system. You stated that you were intending to strengthen this system. Have you taken any affirmative action in this regard, and can you tell us what you are thinking about?

Secretary WEINBERGER. We have some proposals. They are not actually formal yet.

Do you want to comment on those?

Mr. CARLUCCI. Dr. Stone at the NIH is looking at ways in which the participation of his office can be made more effective in the peer review system. I would have to ask him to submit for the record the kinds of things he is doing there.

Secretary WEINBERGER. I might say this: Basically, one of the problems is that with the number of grants and the narrowness of the fields involved, you frequently have people serving as part of the peer review organization who may also be applicants for grants themselves in other connections. We want to be sure that there is independent expert examination of each of these applications and that the priorities that are assigned to the applications and the actual awards that are made, are done on the basis of disinterested expert advice.

We are trying to insure that that happens. We are also trying to insure that the process is strengthened in a way that takes into consideration the overall requirements of the Government. For example, you may not want to have only people in the arthritis field looking at the applications that are made for grants to do research in arthritis.

You might want to have people familiar with all the work the National Institutes are doing to make sure there is not overlap or duplication.

This is what we mean when we say strengthen it. As for the precise ways in which this would be done, Dr. Stone, who is the Director of NIH, would be glad to take that up with you.

Basically, the idea of having experts review the applications and give their recommendations, which is the essence of the peer review system, will remain in effect.

Mr CASEY. The only criticism I have heard of the peer review system was from one man who felt there was no one on the review panel who was not antagonistic to his approach to the problem he was trying to investigate. He, of course, is not against the peer review system. His only criticism was that those who were in his particular field had a diametrically opposing view about how the research should be done. His was what he considered innovative and different, and he thought someone who had some familiarity with his theory should also have been represented on the review panel to speak a word for him.

Secretary WEINBERGER. This is one of the things we have in mind with respect to the word "strengthen," and also with the idea of getting a somewhat broader look at it, because frequently the field is so narrow that the same four or five people are reviewing each other's applications, and that presents obvious problems, as you can see.

CONSTRUCTION OF MEDICAL SCHOOL FACILITIES

Mr. CASEY. Do you have any request for funds for the construction of medical school facilities?

Secretary WEINBERGER. No, sir, we do not. We believe that the present plant, so to speak, that we have supported and that has been built to some extent with Government funds, is adequate for turning out the number of doctors that will be needed in the 1980's and 1990's. We do not plan to subsidize further construction.

Mr. YOUNG. But there are available for obligation in 1973 and 1974 approximately $244 million. Those funds will be obligated for those purposes.

Secretary WEINBERGER. That is right. I thought you were speaking of the 1975 budget.

Mr. CASEY. I was, and my next question is: How much money do you have left?

Secretary WEINBERGER. That is what we have left.

Mr. FLOOD. If and when an application is received, do you have any way to prevent the construction of these Taj Mahal type of things?

Secretary WEINBERGER. Yes, indeed, sir. We also want to make sure the facilities are not duplicative and are really required, and would serve the purpose for which the 1973 and 1974 money was appropriated.

Mr. CASEY. You have had some medical schools—I know of one—that started their construction several years ago with a master plan that is basically prudent. You have helped with some of the building. Based on what they submit to finish up their program for a medical school, they might qualify for some of the remaining funds?

Secretary WEINBERGER. They might, indeed. Of course, they would have to come in with a formal application.

The basic problem of medical schools started perhaps 3 or 4 or 5 years ago with a 15-year plan is that we would not be able to do all of that because there is no way in which the one appropriation or Congress can commit funds way out in the future. Certainly, schools that have received grants are eligible to come in and make application for the remaining funds.

I do not think a deadline has been set yet for the receipt of those applications.

Mr. YOUNG. No, sir.

Mr. FLOOD. Have you had any request at all from black colleges and universities for funds to construct a medical school or to install a medical school in existing facilities on their campus?

Secretary WEINBERGER. We have the developing institution fund program, and we make substantial grants under that, but that is not construction. I do not know of any.

Mr. MILLER. We have that through direct appropriation.

Secretary WEINBERGER. None that I know of.

Mr. CASEY. Mr. Secretary, as usual, you have made a fine presentation.

Secretary WEINBERGER. Thank you very much, Congressman.

Mr. FLOOD. Mr. Patten.

EDUCATION FOR THE HANDICAPPED

Mr. PATTEN. Education for the Handicapped appears at page 192 of the justification book. Last year the estimate was $157 million. This year, apparently you are asking for $99 million.

We have a blind and deaf school which received some money for the first time last year.

Mr. CARLUCCI. There is an additional $50 million in the consolidated education bill that has to be added to that. I do not have that particular book that you are reading from. I think you are looking at the project grant figure. In the consolidated education bill, there is additional money for handicapped of some $50 million. It is on a comparable basis. It is not a cutback in funds.

ADULT EDUCATION

Mr. PATTEN. I have in my district 11 night schools for adult education. From page 186, it would look as if there is about a $75 million cut in this program.

Mr. CARLUCCI. There is an additional $63 million in the educational consolidation proposal. There is no cut in adult education or education for the handicapped.

Mr. PATTEN. We are the recipients in New Jersey of the old Bankhead-Jones, and also the permanent second Morrill Act. Apparently in this budget you intend to amputate both of those. That is the first time around for that. You ask for nothing for the advanced cost of construction.

Mr. CARLUCCI. For the land grant colleges, advanced cost of construction, there is no request for funds.

Mr. PATTEN. I do not know what you see nationally, but from what I see in my district, I would want to put it back. Sometimes you are justified in some of these vocational programs.

Secretary WEINBERGER. In the bill that we are talking about, there would be funds that the States and school districts could use for this purpose if they wished to do so, Federal funds that would not be limited or bound. If they wished to use these, they could do so.

They could also, of course, use the revenue-sharing funds.

We have requested the termination of both of these on the ground that these narrow categories are no longer required for that purpose.

Mr. CARLUCCI. In addition, it is my understanding there are increases pending in the GI bill which would handle some of the veterans' problems.

LIBRARY RESOURCES

Mr. PATTEN. That will not help the work we do with our colleges. Some of the best work done for the veterans' is at the college level.

The most lovely sites in my district are the new libraries we have. In my town, Andrew Carnegie Foundation I think over 60 years ago, put up a little library. It stood there a long time. The same way in New Brunswick. That is all that ever happened until the Federal Government helped for library construction.

When I came to Congress, all you had was a rural library program. I remember how peeved I was that we had $40 million for library construction, and a friend of mine voted to cut it in half, to cut $20 million off. That was back in 1964 or 1965.

My county has some beautiful libraries. A few towns still need a little priming of libary money.

Also, college library resources training and demonstration money apparently is omitted.

Secretary WEINBERGER. We have asked for a substitute for that in proposed legislation which is being drafted and which would provide a $15 million program to aid public libraries generally. It would improve the expansion and exchange of information between libraries in particular areas.

We do believe that the actual operation and construction of college libraries, and so on, should be a responsibility of those institutions. This $15 million program would aid in the exchange of information and would go in a project grant program that would target the assistance on the special groups that most need it.

Mr. PATTEN. On page 179, the bilingual education get a big zero.

Mr. CARLUCCI. We have asked for an extension of title VII. We have requested $35 million for the bilingual education demonstration program under title VII.

Mr. PATTEN. I have a long list here. I will not go through the whole listing.

CANCER PROGRAM

I am not going to sit here and vote $600 million for cancer to see it just go to private companies for profit. I would like to see a few dollars go to schools that have earned their spurs, like the microbiology group at Rutgers that discovered streptomycin. I would like to see a little increase in the college nonprofit laboratories grants, with less emphasis on contracts.

I took this up with Dr. Rauscher of the National Cancer Institute. It would seem to me that if we are to appropriate $600 million, some of these fine chemists and physicists and others that we have at the college level who are doing basic research are entitled to a little consideration.

Have you seen the financial reports of the drug companies showing their profits from all those pills? You should have bought drug stock 10 years ago. You would not have to be sitting here.

I really think that some of these colleges that have been doing fine basic research ought to get more consideration. I fail to understand it.

Secretary WEINBERGER. The grant portion of the program goes through the peer review system. They do allocate the sums that are available on the basis of how those particular applications fit in with the basic national cancer plan. The rest of the program is allocated by the Institute itself.

As you recall, the Institute has very substantial autonomy. The recommendations they make are nearly always followed. How they are allocating the money is essentially within their own discretion. They do have autonomy that is not found in any of the other Institutes. They do use the peer review system for the great bulk of their grants, which means, of course, that they follow recommendations of people in the field.

There is substantial funding for several treatment centers throughout the country. My understanding is that Rutgers is one of those.

Mr. PATTEN. That was a great speech you just made about their being autonomous. If you are not the boss, I do not know who is.

Secretary WEINBERGER. We do not disclaim responsibility, but we think it proper to point out to you that the Cancer Institute, by action of the Congress, is in a very special category. It is not in the same category as the National Institutes of Health. It has a number of different features which differentiate it.

Mr. YOUNG. We do not review their budget.

Secretary WEINBERGER. We are not even allowed to review their budget.

SUPPLEMENTAL SECURITY INCOME PROGRAM

Mr. PATTEN. May I just close and say the new program that we started January 1 under social security where 3 million people now have a chance to live under SSI is wonderful. I never thought you would make it. It looked like a terrible jam in January and February. I thought the whole thing would break down. When people make fun of the Government I say the most beautiful chapter in the United States is what you have asked for in this book. This is good living, good Government.

Mr. Weinberger, you ought to be very happy. You ought to shout out loud that your Social Security Department has done a great job in the last 3 months.

Mr. FLOOD. Mr. Patten couldn't have done better himself.

Secretary WEINBERGER. It is very nice of you, Congressman, and I do take enormous pride in that. That is one of the things I had in mind when we were speaking of the morale of the Department. If we had bad morale in the Department, they could not possibly have put that massive and large scale a program in effect with accuracy and do it on time, and they did it on time. It is a great source of pride to me they did that.

Mr. PATTEN. What change in Government could you compare it to? I think it is of the greatest magnitude what you have done in your Social Security Department in the last 3 months.

Secretary WEINBERGER. I would not be inclined to argue with you.

Mr. FLOOD. We will recess until 10.

WEDNESDAY, MARCH 20, 1974.

Mr. NATCHER. The committee will come to order.

Mr. Obey.

Mr. OBEY. Thank you, Mr. Chairman.

DRUG REIMBURSEMENT

Mr. Secretary, I think before Mr. Michel returned yesterday we were talking about your efforts to insure that the low-cost drug alternative would be the one paid for by the Government under medicaid and medicare.

Secretary WEINBERGER. Yes, sir.

Mr. OBEY. I noticed Mr. Stetler from PMA attacked your assertion that you could fairly safely assume equivalency for most drugs under the same generic classifications. In fact he was quoted before Senator Kennedy's committee. When Senator Kennedy said, "Why does the Secretary of HEW do a thing like that"—namely assert the equivalency when Mr. Stetler said it was not possible to really determine equivalency—Mr. Stetler said, "I can't account for him, but I think it is a shocking piece of testimony."

I, for one, don't think it is a shocking piece of testimony. I think you are right. But, for the record, I wondered if you would care to respond again in explaining on what you based your assumption there is a way of determining equivalency.

Secretary WEINBERGER. Yes, sir. We have, of course, [illegible] on the Food and Drug Administration which is part of our Department. But, generally speaking, the policy that we announced was to the effect that when the doctor ordered a specific brand medication, there is nevertheless some other equivalent medication at a lower cost, we would only reimburse at the lower cost. We would have to be sure that the drugs that constituted the medication were of high quality and would come up to their label specification of potency, including such things as time within which they dissolve.

We would have to rely on the Food and Drug Administration which as part of their duties have the responsibility of assuring that medication on the market, first of all, meets its specifications and is of the required and designated purity and so forth.

We are assured by the Food and Drug Administration that this can be done, and necessarily I would rely on that advice. It involves and requires the Food and Drug Administration to do their job in the same way they have to insure the purity and equivalency and all of the rest of other drugs or other substances on the market. But that is the mechanism we would use.

Mr. OBEY. What is your estimate of the cost saving that would accrue to either the Government or the purchaser under those programs if you do go through that kind of program?

Secretary WEINBERGER. We had various estimates that range from $48 million up to over $100 million that could be saved to the Government by this policy. The total drug purchases run in the neighborhood of $1 billion, and we felt there could be quite substantial saving.

Mr. OBEY. That is for what?

Secretary WEINBERGER. For the medicare and medicaid programs in which the Government itself finances the costs. We believe that savings in that amount could be made and perhaps considerably higher.

We also believe it would have a marked effect on the public in general who do not participate in medicare-medicaid programs because the present pricing structure or system would not exist very long.

Mr. OBEY. I agree.

Secretary WEINBERGER. So we believe the ultimate savings to the public would be in the neighborhood of $1 billion.

Mr. OBEY. You are saying under the program itself you could be saving 10 percent of costs?

Secretary WEINBERGER. I think at least that. I try to use as conservative figures as possible. I think that would be a fair estimate if we can get the program adopted on a nationwide basis so to speak. This would require some months to get people familiar with it. If we get people used to the fact there is a different policy in effect, and have druggists supply the lower priced equivalent, then I think in a comparatively short time we would be seeing savings of that sort and the public would be seeing a savings in their general drug purchases.

Mr. OBEY. I hope you stick to your guns on that because I think you are absolutely right on it.

Secretary WEINBERGER. Thank you, sir.

CONFIDENTIALITY OF BUDGET PROCESS

Mr. OBEY. Let me ask something else. I noticed an article in Science Magazine a while back discussing the confidentiality of budget justifications—I quote:

> One thing that many government scientists involved in preparing these budget justifications resent is the confidentiality in which they must be held.
>
> The justifications at the Institute of General Medical Science submitted along with the budget request for fiscal 1974 is representative. The document, an attempt to explain why certain research in molecular biology, genetics and other basic sciences should be supported, had stamped conspicuously across the front, and the front of every page, OMB decreed, "Administratively Confidential. Exercise caution in handling this document." One would think it a letter bomb.

Why do you think it is necessary that those justifications be confidential or do you?

Secretary WEINBERGER. I think this is necessary. The article you are quoting illustrates the ineffectiveness of the policy because all of these documents are always in the public domain.

But generally speaking I believe they should be entitled to the same kind of protection that a preliminary draft that one of your staff might prepare for you. For example, a speech or something of that kind should remain confidential and not be released as your speech until you might release it or make it. These documents are the preliminary preparatory documents that go into the makeup of the President's budget, and until the President decides what is to be in his budget, then it should not be released. The Budget and Accounting Act put upon him the responsibility for submitting to the Congress his recommendations for funding, and when he decides what that is to be, the final version should be sent by him. In the meantime everything else I think is preliminary working papers and doesn't constitute anything that is either final or his decision. It constitutes suggestions to him as to what should be in his budget.

The Budget and Accounting Act of 1921 states that the agencies of the Government should do their budgeting in a unified way, as you know, and that the President is the one who should make those recommendations to Congress. The Congress is perfectly free to move them up or down or not adopt them at all, or do anything they wish with them.

The President is not only entitled but is required to submit to the Congress his recommendations. The preliminary documents that go into assisting him in making his final recommendations I don't think are public property or should be. I think they confuse the issue very much, and they tend to distort and confuse the Congress on just what the President is actually recommending.

The reason that the Science Magazine makes that point and that the people who make up these budget requests are resentful of the confidentiality requirement is simply that they often will not agree with the President's final determination as to how much the National Institute of General Medicine or whatever should have.

A budget justification is a propaganda document necessary for the person making up that request and constitutes his strong arguments as to why he would like to have $25 million instead of let us say $15 million more than the President feels can be allocated under the overall fiscal requirements of the Government. The individual making up a single program request within a department can't have any real way of knowing what are the overall fiscal problems of Government and can't coordinate his requests with those overall requirements.

Mr. OBEY. I think it is obvious that we know that.

Secretary WEINBERGER. Sure.

Mr. OBEY. We know that people when they prepare their own budgets don't take into account how many bucks you have got to spread around the programs. But you say that that ought to remain confidential in the same way that a staff member's initial draft of a speech for me ought to remain confidential. You have given kind of a speech. Let me give one in return.

Secretary WEINBERGER. Surely.

Mr. OBEY. First of all it would seem to me any speech prepared for me is quite different than a budget document prepared for the National Institutes of Health because a speech for me is simply the assertion of one man's view on the subject, whereas the budget document represents the best judgment of the people who have the responsibility within the administrative branch of Government——

Secretary WEINBERGER. It may or may not.

Mr. OBEY [continuing]. To carry out the entire Federal program. You say there is great difficulty on the part of Congress if those justifications are made public, there is great difficulty with the Congress knowing what the President is in fact for. I don't think so, but I think there is a great deal of difficulty in our knowing what the people who know most about these programs really feel about them. When first of all they have to come up here before this committee and voice what is administration policy, it is very difficult for us to obtain their own personal views as to what amounts are needed to make the programs effective.

Let me just cite an example to you. I come from the State of Wisconsin. Our Governor doesn't put together his budget in secret; in fact his own budget hearings are held in the public. The pleas which are made by agencies to the Governor on their budget are public. The press is there, members of the legislature including the finance committee can be there if they choose.

The Governor in our State makes a great case about how much he has cut from each of the budget requests to him. He doesn't regard it as an embarrassment that he has had to cut out money; he often regards it as a plus.

It seems to me, in light of the fact that you indicated that the policy in many cases is ineffective anyway because many of these documents are leaked, that in the interest of candor, in the interest of informing a committee like this, those justifications ought to be public. You run the risk otherwise of getting in this new budget control bill which the Senate is debating today a huge new Congressional Office of the Budget precisely because we cannot obtain the kind of backup viewpoints expressed in those budget documents. I think there is a strong case to be made on the other side.

Secretary WEINBERGER. I think you have to go back and look at the policy under which the President has been operating since 1921, and that is a policy enacted in the Budget and Accounting Act, which takes the position that the budget is a single unified document submitted by the President and that, for example, no agency can ask for a supplemental under the statute unless the President formally transmits it as something he wants, and no agency is really authorized under the intent of that act to go up and say that the budget submission that is made for them is wrong, that they want more, or anything of the kind.

The responsibility for submitting the budget is located in the Office of the President. If the Congress wishes to change that policy, obviously they can because that is where the policy came from. But the policy under which the President is operating and every President has operated really since 1921, as far as I know, has been that the budget is the requirement, the prerogative, and the responsibility of the President—to assemble and submit. The documents that go into its preparation are necessarily preliminary and confidential worksheets.

Mr. OBEY. Of course it is the President's job to do that and of course the budget is his responsibility. But isn't Congress entitled to know what the different policy alternatives were before the President finally made his decision? Couldn't he share the justifications with us? Couldn't in fact there be the possibility of less conflict instead of more if we were supplied with those kinds of materials?

Secretary WEINBERGER. I don't know, and I don't know really whether the purpose of the policy is to prevent or promote conflict. But the basic fact that I think is important is that if all of the requests for each of the agencies were submitted in their original form—and I am sure you know it is the nature of the beast that every agency, every department manager, every program head is going to ask for more than he thinks he can possibly get because he knows he is going to be cut back——

Mr. OBEY. That is true.

Secretary WEINBERGER. And if all of those are available and are considered, I think that first of all you are going to duplicate the process that the President had to go through in order to make his decision. Second, you are going to be doing it without the overall requirements of resources and inflationary factors and general economic conditions that the President has to have before him when he makes up the budget.

Finally I think you are going to simply set each particular agency head against each other and against the President and thrash out the whole budget process within the Congress rather than having the Congress take a completed document and do with it what the Congress seems to them best as a result of their hearings. I think the process we have is not only more orderly but it is more likely to produce a budget, given the congressional input, that is in keeping with national priorities and with the available resources.

Mr. OBEY. I think it is more orderly, but I doubt very much it is a system which would provide the most light on policy differences.

Secretary WEINBERGER. I have never found any situation in which the Congress wasn't able to either increase or decrease the President's budget on the basis of information that they could get at the hearings. But the process of making it up, the process of submitting it, which is pretty much a year-long process, is an enormously difficult technical task for one thing, and second, it has to be done I think with the knowledge of the available resources of the overall Government and the overall economic conditions that are presumed to be going to occur when the budget takes effect.

All of these things have to be kept in mind, and I don't think an individual committee hearing on the initial requests of an agency for what he knows is more than he can get is going to be particularly helpful.

Mr. OBEY. As you know it isn't just dollars which agency heads may get, it deals with a good deal of other information as well.

Secretary **WEINBERGER**. Oh, yes, personnel ceilings and program justifications and all the rest. But it seems to me that these have to be prepared in a way that is consistent with all of the other activities of the executive branch.

Mr. **OBEY**. It may fit the need for the executive branch, but I don't think it fits the need for the Congress very well.

Secretary **WEINBERGER**. I think the congressional role is very historic and a very important [illegible], and it is to challenge the executive branch recommendations. That is all the budget ever is—it is a recommendation for enactment of a bill or series of bills, and the Congress hasn't been hesistant during the time I have been here to make substantial changes in each of those recommendations. I haven't sensed any inability on the part of the Congress to deal with the President's budget as the Congress wishes, and I don't think there should be any inability. But I think if you flood the system with a lot of preliminary inflated requests from people who want more than they know they can get, and every manner I have dealt with in the time I have had anything to do with the budget is in exactly the same category, you aren't going to have a very orderly or useful project.

Mr. **OBEY**. I think we are going to have to disagree on that.

NATIONAL HEALTH INSURANCE

On national health insurance, we have the administration bill versus the Kennedy bill. One of the issues contained in that area is the question of whether you are going to have programs run by insurance companies or the Government. I am not necessarily willing to assume that the Government can do a better job of it than insurance companies, but I do have one other concern because of your attitude on trying to do whatever can be done to keep drug costs down. That is the extreme reliance in the administration new health insurance bill on State regulation. That I think is probably the weakest link in the administration bill because while in some States you may have fairly strong regulations to keep costs down, I think in the majority of States regulation by insurance departments is regulation in name only. I just wanted to get your response to that.

Secretary **WEINBERGER**. First of all, Congressman, I would disagree with you that our bill has the insurance companies running anything. It does not. It has the private insurance companies remaining in business and making reimbursements for claims on the basis of the guidelines and the coverage and the benefits in the programs themselves, but they don't run anything. They don't deliver health services, they don't operate hospitals.

Mr. **OBEY**. I understand. I didn't mean it in that context.

Secretary **WEINBERGER**. On the State regulation, I think Wisconsin has very good regulation of insurance.

Mr. **OBEY**. So do I.

Secretary **WEINBERGER**. I know California does. I am surprised to hear the Pennsylvania Insurance Commissioner saying his State does so badly in this because he makes such a point nationally of saying how good he is. But when it comes to assigning a new task to him he immediately says they do things so badly in Pennsylvania that insurance companies would not be regulated.

I think there is a far better chance of good regulation if it is done by States, and I think if the regulation is not done at all by States the Federal Government would take over. If it is done badly you have a far greater chance of correcting deficiencies at local levels of government that are closer to the people than the Federal Government.

I am sure this is another philosophical difference you and I might have. But I don't have any hesitancy, based on the type of insurance regulation I have seen in New York and California, in Wisconsin and so on, that I know exist, and I have no worries that we are going to get satisfactory and adequate regulation of prices and costs and other factors through insurance company regulation if they are administered at the State level. I have a great deal more faith in State and local governments than many people who have been only associated with the Federal Government.

Mr. OBEY. You have Federal regulations which require States to tighten up on welfare rolls for instance.

Secretary WEINBERGER. No. We are asking the State governments to do it as they wish. We are simply telling them that the error rate they themselves have reported is much too high. We are saying a number of States have had very good results in reducing that error rate, here are some of the methods they use; we will send technical teams in to help you, and you can implement these methods if you wish. We are saying that the Federal Government funding and matching of the welfare program will be reduced to the point that it will finance a much less rate of error than is presently the case.

Mr. OBEY. All I am saying to you is that I would prefer to support something which does not go the complete distance that the Kennedy bill goes, but I would find difficulty supporting the administration bill as long as there is not some additional guarantees that because States have nothing more than pattycake regulation in some areas of the country, costs would not go out of sight.

Secretary WEINBERGER. As you know, I am sure, there would be general Federal guidelines with respect to the regulation and with respect to reimbursement policy and so on.

I am very conscious of how rapidly health care costs have increased. I think that was the result of a faulty design in the implementation of the medicaid and medicare program in the midsixties. But we believe that the cost controls that we are recommending be built into the health insurance plan will be adequate and will do the job. I will say, if the Congress does not extend the President's authority to control health care costs after April 30, there will be a very difficult time, because you will then have the situation where health care providers will not be under regulations after April 30, and knowing that a health insurance bill with regulations is coming along, then they may very well try to take care of that contingency by raising prices during that interim period. That, I think, would be very serious.

HEALTH MAINTENANCE ORGANIZATIONS

Mr. OBEY. Let me ask you a question on HMO's. We were told during the supplemental hearings that at the present time, none of the existing HMO's in the country would qualify for certification under that new bill, but that the Department of Health, Education, and

Welfare would try to work it out through some kind of a waiver arrangement with the Secretary's Office. Do you have any more information?

Secretary Weinberger. I can't say none of them would qualify. The bill certainly provides for a substantial number of new criteria which a new HMO must meet in order to qualify for Government financing of planning or start up costs.

Mr. Carlucci. I think probably a couple of problems are there. One is the rather rich packages of benefits contained in the bill and which, you may recall, the administration opposed, and was resolved essentially in a compromise which allowed copayments at the Secretary's discretion. So if we are going to have to use the copayment feature to allow HMO's to qualify under the rich package of benefits, then it is correct to say that existing HMO's, most of which do not meet this package of benefits, could not qualify without the Secretary's discretionary power being used.

The second, of course, is the problem of dual choice and how we implement regulations on that working with the Department of Labor. This is a more complicated issue. Our regulations are going to come out in two steps.

So I think that statement really applies to certain technicalities in the law rather than our ability to implement the law. I think basically there is enough flexibility.

Secretary Weinberger. I would like to add another thing. That is almost by definition existing HMO's were not to be funded by the new bill. The primary purpose of the new bill is to foster the planning, design, and establishment of new HMO's.

Mr. Obey. I think there is some disagreement there. Mr. Carlucci mentioned the mandatory dual choice requirement. It has been suggested, for instance, by some sources that existing HMO's just be grandfathered in at least temporarily, and when we had witnesses before the subcommittee, they indicated that was one possible route which might be taken by the administration. I see you shake your head.

Mr. Carlucci. I am not acquainted with that particular testimony. The reservation I would have on that is as follows: The congressional intent is very clear that this is to be a demonstration program, and that we are going to have to have a variety of models. So if you are going to have a controlled demonstration, almost by definition you can't grandfather everybody in. So we would have to look at the existing HMO's on a case-by-case basis.

Mr. Obey. I am speaking of the Kaiser plan or in my own State, the Marshfield Clinic plan. The new HMO legislation has that mandatory dual choice requirement. If somebody like Marshfield Clinic can't qualify under the new bill, that in effect makes that mandatory dual choice requirement superfluous because nobody in the area is going to be able to use the Marshfield Clinic. Employers won't be able to offer it to their employees, and the administration will have won by regulation what it lost in the legislative argument.

Mr. Carlucci. We did oppose the dual choice provision, as you know.

Mr. Obey. I know you did.

Mr. Carlucci. The issue was whether it applied universally or just to HMO's under the bill, and I quite frankly can't tell you off the top of my head how we are going to get around that type of problem, but it is a subject under intensive review in the Department.

Secretary WEINBERGER. There certainly was no suggestion that the bill which the President signed in December was to pay operating expenses of existing HMO's. The bill was designed to foster the test of a whole new series of HMO's.

Mr. OBEY. That is a separate question. I am not talking about paying operating expenses. I am talking about whether or not 16,000 people for instance who now belong to the greater Marshfield plan will be able to qualify for the benefits under the dual choice arrangement.

Secretary WEINBERGER. We are trying to deal with that problem through the dual choice regulations now under development. But under the demonstration provisions of the bill passed in December we do not plan to fund existing successful HMO's, such as Marshfield, Kaiser, or any of the others.

Mr. OBEY. Do you have something to add?

Mr. CARLUCCI. I think the point you are making is not related to subsidizing existing HMO's but pertains to allowing them to qualify for the dual choice option. We don't have a categorical answer to that problem right now, but we are looking at it in the context of the regulations that will be developed.

Secretary WEINBERGER. The administration's health insurance bill does provide that the employee can choose whether he wants his protection furnished through a HMO or through regular, fee-for-service insurance. If he chooses a HMO we would certainly want to accommodate him by having him able to join a HMO of his choice, and we would only want to assure ourselves that HMO would provide the services covered and give him the benefits offered by the bill.

Mr. SMITH. Will the gentleman yield?

Mr. OBEY. Yes.

Mr. SMITH. What is your timetable on choosing the HMO's?

Secretary WEINBERGER. If the bill is passed this year, which we very much hope it will be, the health insurance bill, it would take effect I think toward the middle of the year 1976.

Mr. SMITH. I am talking about the HMO's demonstration?

Secretary WEINBERGER. We are receiving many inquiries now.

Mr. OBEY. March 29?

Mr. CARLUCCI. Yes, the regulations are due to come out about then. There is a meeting scheduled in my office very shortly. But the dual choice regulations are not going to come out at the same time. They are more complex. We have to work with the Department of Labor.

Mr. OBEY. When will they come out?

Mr. CARLUCCI. We are shooting for probably May or early June on the dual choice regulations.

As you know this is a complex area. We have to take a lot of things into account. But we are moving ahead on the regulations as fast as we can.

BASIC EDUCATION OPPORTUNITY GRANTS

Mr. OBEY. Just one question on BOGS, Mr. Secretary. Much has been made of the administration's new federalism program under which you decentralize decisionmaking authority. Doesn't the BOGS program really go counter to that philosophy?

Secretary **Weinberger**. No, I don't think so. It decentralizes the decisionmaking power into the student himself. It moves from State government or local government institutions right to the student. It gives the student the funds with which to make the decision on their own as to which institution they wish to use.

Mr. **Obey**. In accordance with a rigid national formula run through a Federal computer which makes it very difficult to adjust for individual problems.

Secretary **Weinberger**. I wouldn't consider that an adequate description.

Mr. **Obey**. What kind of choice does the individual student really have under the BOGS program?

Secretary **Weinberger**. He can pick any institution at which he can be admitted and go to it, and he has the money given to him by the Federal Government. He has the widest possible choice. He does not have to go through a particular institution which has been given the money and then have to satisfy that institution he is entitled to the loan or grant. He is given the grant. It is a Federal scholarship given to the student.

Mr. **Obey**. He has the same degree of real choice under the supplemental grant!

Secretary **Weinberger**. No he does not. That is the principal difference between the two. With the supplemental grant he has to satisfy some one of 5,000 student aid officers of various institutions around the country using varying rules. Under the BOG program he has certainly to establish that his family is within the boundary lines set by the family contribution scale. But once that is done, once it is established that he is eligible for the program, then he can use the funds anywhere he wants at any institution to which he can secure admission.

Mr. **Obey**. The way the BOGS program was sold to me a few years ago was that we were told the beauty of that program was that it would give everybody a basic entitlement and problems in terms of eligibility because of rigid requirements could be taken care of by slopover from the EOG program. If I understand your justifications correctly, now you are suggesting the same thing you did last year, the elimination of EOG.

Secretary **Weinberger**. We are suggesting that the BOGS program substitute for it.

Again with respect to the comment you made a moment ago about the rigidity of the family contribution schedule, which is the entrance to eligibility for the BOGS program, that is not only discussed by the Congress every year but has to be approved by the Congress. It has been approved now that we will be able to move on this program much earlier this year than we were able to last year, which was the first year of its existence.

NATIONAL INSTITUTE OF OCCUPATIONAL SAFETY AND HEALTH

Mr. **Obey**. Let me turn to NIOSH. There is a quite substantial cut as I understand in NIOSH's budget. As I understand part of that is due to an initial one-time item. Is that right?

Mr. MILLER. The whole thing is due to the fact there was some construction money added in the supplemental by the Senate for modernization of some existing facilities. It was accepted by the House in conference. It is a one-time cost, and I think, accounts for the reduction.

Mr. OBEY. How many positions are being added for NIOSH?

Mr. MILLER. Forty new positions are requested for NIOSH in the 1975 budget.

Mr. OBEY. Doesn't that in fact only restore 40 of the 96 positions which were cut the year before?

Mr. MILLER. I am sorry I don't have the difference between 1974 and 1973 in NIOSH. We will have to get it for you.

[The information follows:]

The 1974 budget for occupational health proposed a decrease of 96 positions below the 1973 level. The 1975 budget would restore 40 of these positions.

Mr. OBEY. Let me read a couple of sections from the GAO report on NIOSH. One section says:

> Due to the magnitude of its task and limited funding plus HEW restrictions on staff, the Institute has progressed slowly in developing and recommending comprehensive standards. Beginning in fiscal year 1974 they will be able to produce only 20 to 30 comprehensive recommended standards and work practices recommendations per year for the 1,000 to 2,000 substances and agents requiring standards.

Because of the fact that cancer occurs at a greater rate for the blue collar working population in the country than it occurs for the rest of us, isn't it pretty hard to justify the continual operation of NIOSH at such a low level budget effort?

Mr. CARLUCCI. It seems to me it is very hard to relate numbers of people to the production of these kind of standards which require a certain amount of basic research. Also it is not a question of just recommending standards, it is a question of the capacity of the Department of Labor to implement them as well. It does no good just to increase your production of standards, if they can't be implemented throughout the industry.

The budget, as presented, was designed to provide a balance between the production of standards and their implementation. It is my understanding, given the start-up time, that the production of standards can increase within the——

Mr. OBEY. When the Director of OSHA was here he said they frankly couldn't use more positions because of the limited amount of scientific evaluation coming out of NIOSH which they rely on very heavily to set their standards. He indicated he couldn't understand why NIOSH had been cut. It was my observation that either his budget is underfunded or NIOSH's is underfunded. I would like to know which one it is.

Mr. CARLUCCI. We just indicated that NIOSH hasn't been cut.

I would be glad to look into that.

Mr. OBEY. It is below the level of 2 years ago.

Mr. CARLUCCI. We will have to submit something for the record on that in terms of overall funding.

[The information follows:]

NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH FUNDING, FISCAL YEAR 1973-75

	1973	1974	1975 (estimate)
Budget authority	$30,112,000	[1] 31,354,000	$27,859,000
Occupational health	27,805,000	[1] 29,129,000	25,848,000
Program direction	2,307,000	2,225,000	2,011,000
Obligations	25,670,000	[1] 35,515,000	27,859,000

[1] Includes $3,582,000 to expand clinical services for occupational respiratory diseases of coal miners. These clinics are expected to become self-sufficient in 1975 (through third-party reimbursements) and will require no further Federal support.

Mr. MILLER. Only in the sense that nonrecurring cost is not in there. The 1973 appropriations was $27.8 million.

Mr. OBEY. What about the postions? Weren't 96 positions cut 2 years ago?

Mr. MILLER. You are correct on that. There were 96 positions cut between 1973 and 1974, and we have only restored 40 in 1975.

Mr. CARLUCCI. They were HEW-wide cuts several years ago, and not all of those have been fully restored.

Mr. OBEY. I understand that but I am suggesting—let me read again from the GAO report:

> Once all research is completed, which might take 3 to 5 years or more, and a draft recommended standard is prepared it is widely reviewed, Institute officials expect that about 12 to 14 months would generally be required for completing research and recommending the standard to the Secretary of Labor.

What they are saying in effect is it takes about a 4- to 6-year process in order to promulgate standards for possible cancer-causing agents in the workplace. I don't know of anybody else but NIOSH who has an active program to determine what kind of people were exposed to various cancer-causing agents in the past.

There are people running around this country, hundreds of thousands of them, who may have been exposed to some kind of cancer-causing agents, and yet this is a standpat budget for the one group in our society which is exposed to more cancer-causing agents than anybody else. I just don't understand why you have this apparent lack of initiative as far as this program is concerned.

Secretary WEINBERGER. Congressman, one of the objectives of the program is to determine whether or not they do face these hazards. There is no suggestion, out of the 2,500 substances that have to be analyzed and researched under an extremely rigorous set of programs adopted by the Congress, that any of those substances are cancer-producing at this point. We simply don't know that.

Mr. OBEY. We don't know. But that lack of knowledge covers 87 percent of the chemicals which people work with every day. It is somewhat alarming to me to hear you say because we don't know we shouldn't worry about it.

Secretary WEINBERGER. I am not saying we shouldn't worry about it. I am saying that if you want to complete this program by next year, you couldn't do it. Even if you put 100,000 people in that Institute it could not be done because of the time that is required for each of these tests and studies and analyses.

Mr. **Obey**. I agree with you. I suggest it is important we start now because it does take that long.

Secretary **Weinberger**. We are well launched, and we have over 100 of the 2,500 substances reasonably well analyzed, I believe. The simple fact of the matter is that you have to make some kind of selection as to what should be done with the available resources.

Mr. **Obey**. So you send up a supplemental here for NIE which you define as an emergency item, much of it ill defined in my judgment, but we let an institute like this go with an increase in positions which restores only half of what was cut 2 years ago.

Mr. **Carlucci**. I wonder if we would be allowed to put in the record the growth in NIOSH over a 4- or 5-year period. I don't have the figures at my fingertips but I think it will show the growth overall has been quite substantial.

Mr. **Obey**. The GAO itself recommended that "HEW should consider the adequacy of the Institute's resources to effectively carry out its responsibility under the act." And this whole report implies they don't have enough resources to come anywhere near meeting the needs of that Institute.

Mr. **Carlucci**. We could probably produce a number of GAO reports that say that about a great number of HEW programs.

Secretary **Weinberger**. We have carefully considered the NIOSH budget and have increased it. But there is no way in which you can speed this process very significantly, and putting 20 or 30 additional people on it is not going to help us identify cancer-producing agents much more rapidly than is presently being done.

Mr. **Carlucci**. If I may make another comment, we have this year considerably more flexibility departmentwide in allocating our manpower resources than we had previously.

We are initiating today—memos are going out over my signature—a departmentwide manpower utilization study, because I am convinced that we are not doing as well as we might in putting our manpower where our priorities are.

During this process we are not going to have major dislocations or major problems. If as a result of this manpower study we determine that additional personnel are needed in NIOSH we will reorder or move people from other areas of HEW into NIOSH.

Mr. **Obey**. I would hope you would.

That is all, Mr. Chairman. Thank you.

Mr. **Natcher**. Mr. Secretary, the next member that I will yield to is Mrs. Green of Oregon. If you asked me to name the five ablest women who have ever served in the House or the Senate since March 4, 1789, in the top five I would place Mrs. Green.

Secretary **Weinberger**. That conforms with our view, Mr. Chairman.

Mr. **Natcher**. I say that to you frankly, Mr. Secretary. Several weeks ago Mrs. Green made a serious mistake and announced she wouldn't run for reelection. This may be her last opportunity to question you on the budget for fiscal year 1975. So, Mr. Secretary, you give her good answers.

Secretary **Weinberger**. I will certainly do my best. I share with you the regret that everyone must feel when we read her announcement.

Mr. NATCHER. Mrs. Green, I yield to you at this time.

Mrs. GREEN. Thank you very much, Mr. Chairman.

ADVANCED FUNDING

Mr. Secretary, I am delighted to see that you are recommending advanced funding for ESEA. Are you recommending that advanced funding for other programs?

Secretary WEINBERGER. We have recommended it for education grants consolidation. I don't believe we are requesting it for the first time for any other programs.

Mr. CARLUCCI. There are several others which have been advance funded.

Mrs. GREEN. BOG?

Mr. CARLUCCI. The student aid programs are advance funded presently.

Mr. MILLER. You may remember about 2 years ago student aid programs were in different cycles and we brought them into phase by requesting an extra half year's appropriation, I forget which program it was. I think it was the direct student loans, and now they are all forward funded.

Mrs. GREEN. Let me recheck the record.

What about the other education programs? Are you recommending that they also be advance funded?

Secretary WEINBERGER. Education grants consolidation is the only new one we made this year and we hope very much there will be an acceptable bill passed. So we can actually get the supplemental enacted. I think the schools need that extra time and advance knowledge as to how much Federal funds they are going to get, and when, to enable them to do their planning.

Mr. CARLUCCI. I think when we get forward funding for the elementary and secondary programs, in whatever format they come out, you will find the vast majority of our educational programs are on a forward funding cycle because most of the others, the student aid and discretionary programs, have been put on that cycle. But we will be glad to submit something for the record on the individual programs that are now forward funded.

Mrs. GREEN. Do "advance funding" and "forward funding," in your use of them, mean the same thing?

Mr. CARLUCCI. Yes.

DEVELOPING INSTITUTIONS

Mrs. GREEN. On the developing institutions, are you recommending phase out of that program at the end of 5 years? That was your recommendation last year I believe. Is that still your policy?

Mr. CARLUCCI. Our position on that is that we want to examine the basic program over the period of the next year to see if that program shouldn't be phased out. I think there is essentially a difference here between the basic program and the advanced program. We will be examining it over the course of the next year.

Mrs. GREEN. Your recommendation last year, as I recall, when you requested the tremendous increase in funds, was that it would be phased out in 5 years. Is that not correct?

Mr. CARLUCCI. That is correct.

Mrs. GREEN. So you are reexamining it?

Mr. CARLUCCI. Yes.

SUPPLY OF MEDICAL MANPOWER

Mrs. GREEN. On critical shortage which you discuss on page 17, did I understand you correctly yesterday to say that you thought there would be an adequate supply of medical doctors?

Secretary WEINBERGER. By the mid-1980's and the period immediately thereafter, yes. We believe we are on a path now with the Government subsidies and private sector enrollments that would lead us to that conclusion, yes.

FOREIGN M.D.'S

Mrs. GREEN. If you do not know today, could you supply for the record the number of medical doctors practicing in the United States who are from other countries?

Secretary WEINBERGER. We can get that.

[The information follows:]

Approximately 68,000 foreign medical graduates, active and inactive, were resident in the United States as of December 1972, the most recent period for which statistics are available.

Mrs. GREEN. Second, would you break that down into the number of medical doctors who come to the United States from what we loosely call the developing countries? Most studies indicate there has been a "brain drain" to the United States in terms of health personnel. My understanding is that we would have a tremendous shortage of medical personnel if we were not receiving the health personnel trained in other countries to whom we send foreign aid. It seems an anomaly.

[The information follows:]

Distribution of foreign medical graduates by country for 1972 (active and inactive)

Philippines	8, 840
India	6, 324
West Germany	3, 536
Italy	3, 486
Cuba	2, 992
United Kingdom	2, 788
Switzerland	2, 584
South Korea	2, 176
Mexico	2, 108
Spain	2, 176
Austria	1, 700
Iran	2, 108
Argentina	1, 564
Other	25, 636
	68, 018

Secretary WEINBERGER. We will try to break it down by those other countries. I will have to say frankly, Mrs. Green, that I don't think by any of our own actions we are draining any brains or anything of that kind. I think what we are doing is our traditional and, as I have seen it, proper policy of having our doors open, our immigration doors open to those who wish to come. And if doctors who are trained in foreign countries wish to practice here I don't believe they should be stopped if they are qualified. If they are qualified to practice and wish to come, I don't think we should neglect or reverse our historic and traditional immigration policy.

We have had a substantial number of doctors trained in foreign medical schools. Some of them have been U.S. citizens who went over for that purpose, and some have been doctors of foreign countries that were trained abroad and who want to come to this country. My feeling has been that as long as they can demonstrate they are qualified to practice by passing the regular examinations, we should not prevent them from coming here if they wish to do so. I am not aware of any recruiting we are doing or anything of that kind other than the natural recruiting the country itself offers.

Mrs. GREEN. But, Mr. Secretary, in our immigration laws we have a requirement that we do not grant visas for permanent residence to people unless there is a critical short supply in our country.

Secretary WEINBERGER. If it is beyond a quota.

Mrs. GREEN. That is right. But isn't it true in terms of health personnel they have been admitted time-after-time above the quota because there is a critical short supply in our own country?

Secretary WEINBERGER. There has been a shortage of trained personnel in the health provider field without any question. It is that shortage we project to be eliminated in the 1980's by pursuing the basic policies that we have followed over the past several years and that are recommended to be continued. We see the shortage being not only reduced, but eventually eliminated, based on the very difficult set of assumptions with which we have to deal, such as to the requirements of changing medical practices, changing hospital practices and all of the rest. And the fruits of all of the research we are doing have led us to propose a number of changes such as the further use of paramedical personnel.

Mrs. GREEN. It seems to me if we could export rather than import health personnel, medical doctors, technicians and teachers, it might be a more potent force than any kind of foreign aid we now send—much of it wasted.

Secretary WEINBERGER. We don't get them from other countries. They come because they want to. I don't think we should deny them that freedom of choice.

We have been temporary exporters under the Peace Corps and Teacher Corps and under a number of other programs, in addition to a lot of volunteer private organizations with trained and highly skilled medical talent, and we are still doing that. We still have very effective mission-run hospitals in Vietnam and parts of China and in various other parts of the world.

ESEA BYPASS

Mrs. GREEN. Mr. Secretary, in the ESEA bill that is coming up there is a bypass in title 1. Would you explain to me how the Office of Education will administer that bypass?

Mr. CARLUCCI. With great difficulty. We don't think we can administer it, Mrs. Green, to be quite honest. It requires an individual evaluation on a vast number of schools. I forget the number.

Secretary WEINBERGER. 16,000 schools or something like that.

Mr. CARLUCCI. We have made it clear we think it is unadministerable.

Mrs. GREEN. I ask that question to get support for my own view. It seems to me an administrative monstrosity.

Mr. CARLUCCI. There is a letter from the Secretary that indicates, in our judgment, the unworkability of that particular provision.

NATIONAL INSTITUTE OF EDUCATION

Mrs. GREEN. May we turn to NIE which you discuss on page 16. That has been discussed at great length and I don't want to plow the same ground, but you are requesting $130 million next year?

Secretary WEINBERGER. Yes.

Mrs. GREEN. And you specify five areas where you think that research is desirable.

Secretary WEINBERER. These are the areas set up by the National Council which under the statute is the policymaking body for this organization.

TOTAL FUNDS FOR EDUCATIONAL RESEARCH

Mrs. GREEN. How many hundreds of millions of dollars is there in the Office of Education for research?

Secretary WEINBERGER. We will have to add up the various bits and pieces and tell you. I would guess it would be somewhere in the $70 to $80 million figure. We can certainly supply it and piece it together. I don't believe we have it this morning.

[The information follows:]

Office of Education: Research and Development Programs; Total Discretionary Programs

Following are two tables. Table A lists Office of Education support for educational research and development activities. Table B lists Office of Education support for other discretionary--or non-formula grant--programs. In total these two tables show all OE discretionary support for FY 74 and 75. In 1974 and 1975, the totals for discretionary programs are $931,153,000 and $721,902,000. This compares with $896,000,000 for 1973.

As Table A indicates, Office of Education support for educational research and development totals $80,968,000 in FY 74, and $71,136,000 in FY 75. This constitutes only about 10% of all discretionary appropriations. The remainder of the funds as shown in Table B are used to support demonstration, training, service, and technical assistance activities. These activities do not constitute the types of programs which are supported by the National Institute of Education; that is, they are not systematic efforts to gather new knowledge about what works and doesn't work in education.

In summary, OE discretionary funds are used as follows:

	(in thousands of dollars)	
Type of Activity	1974	1975
Table A -- Research and Development	$ 80,968	$ 71,136
Table B -- Other Discretionary Programs		
Service	$447,334	$317,174
Demonstration/Training	133,773	92,639
Demonstration/Service	81,803	82,087
Training	90,522	56,630
Demonstration	31,659	40,534
Construction	31,425	22,252
Service/Technical Assistance	21,700	21,700
Planning	11,969	13,750
Dissemination	---	4,000
Subtotal	850,185	650,766
Total	931,153	721,902

Of the Office of Education research and development activities listed in Table A, the Education for the Handicapped and Vocational Education activities have been retained at the express direction of the Congress. Follow-Through remains with the Office of Education because the program is in the process of being phased out and for this reason was not transferred to NIE. The other activities are relatively minor programs which relate to other Office of Education programs and have been retained for that reason.

Table A

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Office of Education

Estimated Support for Educational Research and Development
(in thousands of dollars)

Appropriation and Activity	1974	1975
Elementary and Secondary Education:		
Follow-Through	$41,000	$35,000
Emergency School Aid:		
Educational Television	3,500	---
Education for the Handicapped:		
Innovation and Development	9,916	9,916
Media Services and Captioned Films	3,900	3,900
Subtotal	13,816	13,816
Occupational, Vocational and Adult Education:		
Innovation--Discretionary Grants	8,000	8,000
Research--Discretionary Grants	9,000	9,000
Curriculum Development	4,000	4,000
Subtotal	21,000	21,000 1/
Higher Education:		
Foreign Language Training and Area Studies	1,500	1,200
Educational Activities Overseas (Special Foreign Currency Program)	152	120
Total OE Research and Development Programs	80,968	71,136

1/ These activities and funds for their support are included in the Consolidated Education Grant proposal for fiscal year 1975. Since these funds will not be earmarked for research and development activities, projections are based on 1974 funding levels.

Table B

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Office of Education

Estimated Support for Other Discretionary Programs*
(in thousands of dollars)

Appropriation and Activity	1974	1975
Elementary and Secondary Education:		
Supplementary Services--Special Projects (D/S)	$20,087	$20,087 1/
Strengthening State Departments of Education--Special Projects (D)	1,734	1,734 1/
Strengthening State Departments of Education--Comprehensive Planning and Evaluation (P)	4,750	4,750 1/
Bilingual Education (D/T)	50,350	35,000
Right to Read (D/T)	12,000	12,000
Educational Broadcasting Facilities (S)	15,675	7,000
Educational Television Programming (D)	3,000	7,000
Civil Rights Advisory Services (S/TA)	21,700	21,700
Drug Abuse Education (D)	5,700	---
Environmental Education (D)	1,900	1,900 1/
Nutrition and Health (D)	1,900	1,900 1/
Subtotal	138,796	113,071
Indian Education:		
Special Projects for Indian Children (D/S)	12,000	32,000
Special Projects for Adult Indians (D/S)	3,000	8,000
Subtotal	15,000	40,000
Emergency School Aid:		
Bilingual Education Projects (S)	9,958	---
Educational Television (S)	3,968	---
Special Programs and Projects (S)	12,447	---
Pilot Programs (State Apportionment) (D/S)	37,341	---
Special Programs and Projects (State Apportionment) (S)	19,915	---
General Grants to Local Educational Agencies (State Apportionment) (S)	146,875	---
Desegregation Assistance Projects (Proposed Legislation) (S)	---	75,000
Subtotal	230,504	75,000
Education for the Handicapped:		
Deaf-Blind Centers (S)	14,055	12,000
Early Childhood Projects (D)	12,000	14,000
Specific Learning Disabilities (S)	3,250	3,250
Regional Resource Centers (S)	7,243	9,243
Media Services and Captioned Films (S)	9,100	9,100
Recruitment and Information (S)	500	500
Special Education Manpower Development (T)	39,615	37,700
Subtotal	85,763	85,793

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*Explanation of abbreviations appears on page 3.

Appropriation and Activity	1974	1975
Occupational, Vocational and Adult Education:		
Career Education (D)	$ ---	$ 10,000
Teacher Corps (D/T)	37,500	37,500
Urban/Rural School Development Program (D/T)	11,529	6,355
Career Opportunities Program (D/T)	22,394	1,784
Categorical Education Personnel Programs (T)	8,399	---
Exceptional Children Education Personnel (T)	3,907	---
Vocational Education Personnel (T)	11,268	---
New Careers in Education (T)	286	---
Higher Education Personnel (T)	2,100	---
Adult Education--Special Projects (D/S)	7,000	7,000[1]
Adult Education--Teacher Training (T)	3,000	3,000[1]
Dropout Prevention (D)	4,000	4,000[1]
Ethnic Heritage Studies (D/S)	2,375	---
Subtotal	113,758	69,639
Higher Education:		
Cooperative Education (S)	10,750	10,750
Special Programs for the Disadvantaged--Talent Search, Special Services in College, Upward Bound, Educational Opportunity Centers (S)	70,331	70,331
Strengthening Developing Institutions (S)	99,992	120,000
Construction--Subsidized Loans (C)	31,425	22,252
Language and Area Centers (T)	9,833	7,440
Fulbright-Hays Fellowships (T)	1,360	1,360
University Community Services--Special Projects (S)	1,425	---
College Teacher Fellowships (T)	5,806	4,000
Fellowships for the Disadvantaged (T)	750	750
Ellender Fellowships (T)	500	500
Subtotal	232,172	237,383
Library Resources:		
College Library Resources (S)	9,975	---
Undergraduate Instructional Equipment (S)	11,875	---
Librarian Training (T)	2,850	---
Library Demonstrations (D)	1,425	---
Interlibrary Cooperation and Demonstrations (Proposed Legislation) (D/S)	---	15,000
Subtotal	26,125	15,000
Educational Activities Overseas (Special Foreign Currency Program) (T)	848	1,880

Appropriation and Activity	1974	1975
Salaries and Expenses:		
Planning and Evaluation (P)	$ 7,219	$ 9,000
General Program Dissemination (Dis)	---	500
Packaging and Field Testing (Dis)	---	3,500
Subtotal	7,219	13,000
Total, Other OE Discretionary Programs	850,185	650,766

1/ These activities and funds for their support are included in the Consolidated Education Grant proposal for fiscal year 1975. Since these funds will not be earmarked for specific activities, projections are based on 1974 funding levels.

* Explanation of Abbreviations:

C - Construction
D - Demonstration
Dis - Dissemination
P - Planning
S - Service
T - Training
TA - Technical Assistance

Mrs. **Green**. But there are $890 million in discretionary funds; some of that is directly marked for certain kinds of research. But it also could be duplicative of the kind of research that NIE wants to do or is doing. When you supply that for the record will you please take into consideration that $890 million in discretionary funds?

Secretary **Weinberger**. We will. Most of that is designed to finance through the grant program, specific kinds of things which would not normally involve a straight research function. And that is the idea of the National Institute; it is supposed to try to do roughly for education what the National Institutes of Health have done with their basic biomedical research programs in the health field.

Mrs. **Green**. As we have looked at it, many of the grants are doing research.

Secretary **Weinberger**. Many of the grants of the Office of Education?

Mrs. **Green**. Yes. Isn't it also true that when you set up NIE the new director—and I must say he has my sympathy—was required to take over a lot of the ongoing research programs that were actually in the Office of Education and that he was also required unfortunately to absorb many of the personnel who were pretty set in their ways?

Secretary **Weinberger**. Yes, that is true. We were trying to centralize the basic educational research function in the National Institute of Education. But that was an extra burden he had to carry and still has to carry. There is no question about that.

Mrs. **Green**. But while you say you want to center it there you still have it divided between NIE and OE.

Secretary **Weinberger**. There are certain statutes which allocate funds to OE and which preclude us from reallocating them. But we are trying to centralize and put into NIE the basic research programs in education. We will obviously not be able to do that completely, because there are some grant programs which have a research aspect and are assigned to OE.

Mr. **Carlucci**. I think it is important to make a distinction here between basic research programs and project grant programs. While there are some programs that remain in OE which could be classified as research, the principal programs remaining in OE would be demonstration programs or project grant programs. There was some discussion on this issue, as I am sure you are aware, with the legislative committees before the programs were transferred in, and there was some resistance to transferring into NIE certain programs that have remained in OE.

MANAGEMENT OF GRANTS AND CONTRACTS

Mrs. **Green**. Mr. Secretary, if I recall correctly, yesterday you said that you had 43,000 grants.

Secretary **Weinberger**. 43,600.

Mrs. **Green**. And you stated "it would be possible for one or two to go wrong."

Secretary **Weinberger**. I am afraid so, yes.

Mrs. **Green**. Do you think that might be an understatement?

Secretary **Weinberger**. Yes, I do. I am constantly worried about it, and it is something that may very well be happening, as you and I are talking, and that we won't know about for some months. With that size program and that diversity it is a constant source of deep concern.

Mrs. Green. It seems to me, along with that statement that one or two might go wrong, that total ought to include that there are 50,000 contracts or grants, and I believe the Under Secretary and others have a difficult time distinguishing between grants and contracts.

Secretary Weinberger. I do too, yes.

Mrs. Green. There were 9,000 that were never closed out. So nobody knows whether they were ever monitored or whether the money was spent for the purposes for which it was given. We do not know if the results were bad or good; or if by chance they were good whether the information was disseminated, or if they were bad that you wouldn't give another grant for exactly the same purpose.

Secretary Weinberger. Mrs. Green, I can't argue with you for a moment, and I can't defend the way in which the programs have been handled in the past. All I can say is that we are trying desperately to get hold of a very large juggernaut that is rushing downhill at an extremely awesome pace. It is a very big task and one that we do feel we need some additional investigative assistance to make sure that, at least where we hear about things, we do have an opportunity to pursue them.

I was frankly appalled at the various factors which you have cited with respect to the handling of these 43,600 grants and some 23,000 contracts with a total, as I said yesterday, of well in excess of $7 billion. The results from those, how they work, the evaluation of them, dissemination of the ones that did work, all of these things are matters that I am afraid we have not pursued.

I am not even very happy with the awarding process. What you do when you come into a situation of this kind is to try to reach the most important things first and make some selection of how your time is to be allocated. We are spending a substantial amount of time and effort in trying to at least get the basic information and to correct some of the deficiencies you quite properly cited about this enormous program.

Mrs. Green. I would certainly say for the record that you are the first Secretary and Mr. Carlucci is the first Under Secretary, whom it has been my experience to know in HEW, who have made any effort to do something about the contract and grant mess. But for the record may I add to the 9,000 in OE that have never been closed out, the 3,000 in the regional offices and 6,000 contracts or grants that are lost. They were filed in some boxes in the basement and nobody can even locate them. So we really don't know much about the results of the expenditures of these funds for the lost 6,000 that were never closed out.

I think, Mr. Secretary, this might explain some of the resistance, certainly on my part, to additional funds for NIE. You talk about the juggernaut. Maybe one of the ways is to just have a moratorium on contracts and grants for a while until we find out if the money for the ones that we have already funded has been spent wisely or foolishly or whether there has been corruption or conflict of interest or absolute waste. I don't see how you will ever get it straightened out if you have hundreds of millions of dollars every year added.

Secretary Weinberger. I think you and I would be in rather full agreement about that, but some of the U.S. district courts and some of your colleagues were not receptive to the basic idea of slowing down or stopping things for a while. It is a continuing source of great alarm because, as you point out, there are substantial additions to this number made each year. It is nothing that can be defended. It does have to be handled in a better way.

That is exactly what we are trying to do and have been trying to do since we came in a year ago. I think it was you, Mrs. Green, who called our attention to another serious problem in the middle of the last year. We got hold of that, a dating problem on some of the contracts, where funds were moved, and so on.

All I can tell you is that we are terribly conscious of it. It is a major priority. We have reported to the committee and to the Congress some of the additional resources we think are necessary to help us get hold of it.

With respect to the NIE, I can only say that I do feel that they would like to move and could move into areas where we need to know more about the process of learning and the process of teaching and the process of managing the school systems and all the rest.

We also need at the same time to get our house in order in a very substantial way with respect to the number of grants that are already out.

Mrs. GREEN. I am not sure whether I interpreted your remarks of a few minutes ago correctly, that you felt the same way, but my colleagues did not. Did that mean that you would approve of the action of this committee stopping the juggernaut by cutting out these funds for NIE?

Secretary WEINBERGER. No; not NIE, because NIE is starting out afresh without this terrible backlog of lost and misplaced grants. It is a new operation which has not really had a chance to get started. I would be hard pressed to argue with you if you suggested stopping some of the things that are already in place.

NATIONAL EQUALIZATION OF ELEMENTARY AND SECONDARY EDUCATION

Mrs. GREEN. Let me bring up one other item that was discussed yesterday and I did not understand your response.

Do you believe in equalization nationally on the elementary and secondary level?

Secretary WEINBERGER. No; I do not. I believe in it on the State level.

Mrs. GREEN. That was not clear to me as I listened to your answer yesterday.

DEFINITION OF DISADVANTAGED

How do you define "disadvantaged"?

Secretary WEINBERGER. The Congress has been working on that for several months. Mr. Carlucci has been in daily contact with the committees on the various formulas. I think perhaps he would be able to give you a better answer than I can.

Mr. CARLUCCI. Do you mean in terms of our prefered formula, Mrs. Green?

Mrs. GREEN. I am not sure what you prefer.

Mr. CARLUCCI. We have always favored the utilization of the Orshansky poverty criteria to the degree possible.

Mrs. GREEN. So, "disadvantaged" is exclusively an economic definition?

Mr. CARLUCCI. It is defined in economic terms because we frankly lack the capacity to define it in educational terms.

Secretary WEINBERGER. I have had discussions of this with Congressman Quie. I agree with you that there can be people who are seriously educationally disadvantaged without any question of reference to economics or anything else, that a child of a high-income family can be very seriously educationally disadvantaged.

The point that I have made with Congressman Quie and that I would make again here is that a high-income family is better able to do something about it than a lower income family. Therefore, it is not improper to define educationally disadvantaged in economic terms because the ability to correct educational disadvantage is not found in the lower income levels.

That is the justification I would have. I certainly agree with you that it is not proper to classify educationally disadvantaged solely in economic terms, but as a question of placing Federal resources, yes, I think they should be income tested because of the difficulty of doing anything about it that they would have.

BASIC EDUCATIONAL OPPORTUNITY GRANTS

Mrs. GREEN. Let me turn to the final question on which I think we have a major disagreement.

In response to a question of Mr. Obey's on the BOG, I believe you defended that program on the basis that it allows the students to have a choice.

What was the average amount of BOG this year?

Secretary WEINBERGER. With the funding we had, $122 million out of the $1 billion we requested, the average grant I think was $260. That went up to $475 when the additional funding was made for fiscal year 1974. The average grant if we got full funding would be in the neighborhood of $700.

Mrs. GREEN. The average?

Secretary WEINBERGER. The average, that is correct.

Mrs. GREEN. For fiscal year 1975?

Secretary WEINBERGER. Yes; that is based on the assumption of the appropriation of the $1.3 billion requested.

Mrs. GREEN. That is an optimistic assumption.

Secretary WEINBERGER. It is, indeed, at this point.

Mrs. GREEN. What is the average cost of attending private college.

Secretary WEINBERGER. I do not know the average, but I would suspect a private college average must be well into the $2,000 range without any question, and probably higher.

Mrs. GREEN. I would say it is above $3,000.

Secretary WEINBERGER. Some are well above that, of course. I am trying to strike an average.

I think the point you have in mind is that the BEOG program will not take care of all the expenses, and there is no question about that. The President has pointed that out many times, both in private discussions with us and publicly. His point is that it is not a bad thing for a student to provide some of the total on his own, or with family assistance. What he needs is a boost. The BEOG would give him the necessary boost.

It is recognized that there would have to be either work done or scholarships of a private nature or additional loans to carry most students if they choose to go to private schools.

Mrs. GREEN. I am not in disagreement with what you just said. That is not my point, however. My point is that your statement prevents the students from having a free choice. If the average award is $260 this year and your private colleges have costs of from $3,000 to $4,500, which they do, and next year the average BOG would be $750 if you got full funding, then is it not true that the student does not have any choice at all until he can put the rest of the $3,000 or $4,000 financial aid package together which would allow him to go to the college of his choice. Therefore, after he believes that he has the BOG, then he must still go to the student financial aid officer at each institution and find out what other funds are available to make it possible for him to attend that college?

Secretary WEINBERGER. I think that is true, but I think that would be true in most programs. He would also go to the student employment office, too, besides the student loan office. He might have to do a number of different things to get the total funds necessary to send him to college.

This has never been devised nor offered as a program which would pay the student's full expenses at any school in the United States.

Mrs. GREEN. That is true, Mr. Secretary, but the point I am trying to make is when you say the advantage of the computerized BEOG over the EOG is that it gives the student the choice ofa college, that statement is really not based on the facts, because the student has no more choice in choosing a college than the student who is on an EOG or a student who is participating in any of the other programs.

Secretary WEINBERGER. In addition to the BEOG program, we are also proposing to continue the guaranteed student loan program under which one can get up to $1,000, which brings him to $1,700. He can get that without going to a student loan office. He can get that simply by going to what we hope will be his increasingly friendly banker.

Mrs. GREEN. The thing I am trying really to explore—I realize you have 300 programs, but I am convinced anybody as smart as you and Mr. Carlucci, has never really sat down and looked at BEOG. You have heard the rhetoric of the people in the Department who have sold you on the idea that this is the greatest thing that ever came down the pike.

I would urge both of you personally to take a look at the basis on which it has been sold, in my judgment fallacious reasoning, fallacious arguments. There is no choice for the student any more than there is in the EOG. He still has to go to the student financial aid officer to get the money.

INCOME TAX INFORMATION

Now let me turn, if I may, to some of the difficulties with the BEOG. Is it not true that the family has to make the IRS form of the family available?

Secretary WEINBERGER. I am not aware of that in any sense being a requirement. It is true the family contribution scale which we have worked out and discussed with the Congress and secured congressional approval of, does require that the program be income tested; that the family assets be taken into consideration.

Mrs. GREEN. I have not looked at the BOG application form recently, but I believe that a close examination would show that applicants must agree to make their IRS form available in order to get the BEOG.

If that be true, do you think this is good policy?

Secretary WEINBERGER. In 1973 the application stated that the Office of Education could contact IRS to validate income information. It also gave the Office of Education authority to request the family to submit IRS information. However, the Office of Education has not gone directly to IRS or has it required any family to submit their IRS form to validate the BEOG application. I do not think this was a good policy That is why in 1974 the application form has been revised so that families are not requested to give the Office of Education authority to go directly to IRS for information.

The Office of Education can request the family to validate their family income but the way you establish income validity in a number of different methods, one of which could be the use of income tax returns.

EXTENSION OF DEADLINE FOR BASIC OPPORTUNITY GRANTS

Mrs. GREEN. Yesterday you said, in explanation of the disaster with the BEOG program this past year, that out of $122 million, only $60 million had been spent. You are extending the deadline to April 1.

Secretary WEINBERGER. Yes, we have done that, but we would not regard the ability to place half of the available funds with students who qualify as a disaster, particularly when we did not get the starting signal until July.

This was for people who were going to college in September. I think, all things considered, given that late a starting date, it was not all that I hoped we could do with it, but it was a few degrees north of a disaster.

Mrs. GREEN. Let me explore the extension of the deadline. This is for this school year, correct?

Secretary WEINBERGER. Yes.

Mrs. GREEN. Which in most colleges ends in either May or June?

Secretary WEINBERGER. Yes.

Mrs. GREEN. They can apply up until April 1, is that correct?

Secretary WEINBERGER. The deadline for submitting applications has been extended to April 1. The students who are eligible may receive a retroactive payment back for the full school year that would close in June.

Mrs. GREEN. Most colleges, as I say, are closing in May or early June. Then by the time they get their application to the college and the college gets its application to the Office of Education and the speed with which the Office of Education works, when would you expect the money to be in the hands of the student?

Secretary WEINBERGER. I would hope under the lessons that we have learned as a result of last year's experience, we could have it in their hands prior to the end of the school year. It could serve as a retroactive payment to enable them to pay back loans or other forms of aid that they have had to obtain because of the late start of the BEOG program.

Mrs. Green. But the purpose of the BEOG program is to make it possible for a student to go to college.

Secretary Weinberger. That is correct.

Mrs. Green. Now that the student has gone to college for a year, you are really not spending it to make it possible for him to go to college. You are making it possible for him to repay his debts.

Secretary Weinberger. We are talking during the first year of the program about first-year students only. I think many of the students who might be required to take until April to get their paperwork, which you have described, completed, may well have gone to college on the hope and with the expectation that they would be able to obtain some kind of BEOG grant during the course of the year.

Certainly, when the program is fully rolling, we would hope to have a cycle under which a student would apply in February for the school year beginning the next September, and he would get his BEOG grant and also then be able to arrange to get a job or do some of the other things necessary to enable him to pay all of the total required for his education wherever he chooses to do it.

Certainly, the program has been slower starting than we would have liked for a number of reasons. The principal reason is that we got a tenth of the amount we requested and it was 6 to 8 months late. When the cycle is underway properly—I hope that will be this year—then I would think it would work in the way we would hope it would work, because we do not plan to do this retroactive funding any longer than we absolutely ha[illegible]o.

Mrs. Green. I must say that people in higher education, to the best of my knowledge, think the extension of the deadline does not make much sense in terms——

Secretary Weinberger. It may not affect more than a very few people. If it affects some favorably, we would be doing what part of the intent of the program is, which is to try to remove obstacles to higher education which stand in the way of many people because of lack of funds.

FUNDING FOR EDUCATIONAL OPPORTUNITY GRANTS

Mrs. Green. What was the amount of funding for EOG?

Secretary Weinberger. $210 million, I think.

Mrs. Green. I had forgotten whether it was $210 million or $270 million.

Secretary Weinberger. $210 million.

EXPENDITURE FOR BEOG ADVERTISING

Mrs. Green. How much money did you spend in your TV commercials advertising BEOG?

Secretary Weinberger. Do you remember, Mr. Young?

Mr. Young. I do not have the numbers.

Secretary Weinberger. It was a contract. It was somewhere in the neighborhood of $400,000. It was not TV commercials. It was an attempt to substitute for the inability that we found ourselves in to get any kind of dissemination of information about the program, as late as it was funded last year. It was only through efforts of that kind that we were able to fund half the students who might not have been funded otherwise.

We did manage, as you say, to allocate $60 million of the $122 million, because we did not get a chance to start until July. We tried to make up for that short period of time by using firms to try to publicize the program and its availability.

Mrs. GREEN. How much money did you spend advertising EOG?

Secretary WEINBERGER. I do not think it was necessary to spend funds for advertising it, because the fact that it had been in places for some time was well known, and the colleges themselves have an interest in utilizing it because they do get an overhead figure from it, and which they do not get from the BEOG progam.

EOG VERSUS BEOG

Mrs. GREEN. Mr. Secretary, you have spoken of the very inadequate amount you had, $122 million for BEOG for freshmen; for EOG for all students in all 4 years and even some in a fifth year program, Congress appropriated only $210 million.

If the BEOG is so superior, how do you account for the fact that every dime of EOG was taken and the colleges and universities were saying if they had more money for EOG it could have been used for the most needy students? Yet with all of the publicizing which you did on TV and radio about the BEOG program coupled with the fact that every student financial aid officer in the country was keenly aware that the BEOG program had passed the Congress and the money would be available, only $60 million was passed on to students. How do you account for the fact that the one has been used up and there has been a great demand for it, and in the BEOG program, for example, Ohio State University mailed 10,725 applications to freshmen, and to date 646 have grants? Nine community colleges in California mailed out 21,970 applications. As of December, only 2.9 percent of their students have the grants. California State universities and colleges, which enroll approximately 270,000 students have only 828 recipients of the grants. Worcester Polytechnic Institute sent 550 applications to entering freshmen. Twenty-three have grants. I could go on and on with the other colleges and universities.

You have advertised the program. It has not been because the student financial aid officers were not aware that the program existed. Yet the educational opportunity grant has, in my judgment, and I think by the record, worked far better than the BOG.

Secretary WEINBERGER. Again let me simply say, in the first place, there is more interest on the part of college loan officers in using the economic opportunity grants because they do have an overhead figure which comes to the college for the use of that program.

We did have a program here which was attended by a substantial amount of uncertainty as to how much, if anything, would be made available for it. It was not until late July, as I recall it, that we had the firm ability to go ahead and allocate the grants. We did advertise it because the other is an ongoing program with which the college loan officers are familiar.

This program, because of the limitations in the funding, could only be applied to young people. Therefore, we had to distribute most of our information to the high schools and secondary schools so the entering students in colleges would have an opportunity to hear about it.

The use of private firms to publicize it was very distasteful to me, but I recognized the reality that we would not get anything like the press distribution of it that we needed at that late stage to make it effective at all.

Obviously, we would not have to use an advertising campaign in future years if we get the appropriation now or made early at a time when we will be able to get that information out to the high schools and colleges that this program is now available.

The family contribution schedule has already been approved by the Congress for this year. So, we are ready to move as soon as we do get the additional funds.

Mrs. GREEN. Mr. Secretary, would it be possible to have one of your bright boys down there who does not have his mind already made up to conform to the "party line," do a real study of what the effects would be if we funded EOG at $1.3 billion as you request for BOG and if we funded BOG at $1.3 billion? EOG has never been funded even to $300 million. If you funded each one at the same level, what really would be the result?

Secretary WEINBERGER. It would take quite a bright boy to produce that result. I would, however, see if we could get any kind of comparable figures along that line.

Mrs. GREEN. I do not limit it to a boy. A bright man or woman who has not already been brainwashed that BOG is the only thing that will provide——

Secretary WEINBERGER. I will have to conceal my disappointment at finding anybody who did not feel BEOG was a superior program in the Department.

In any event, we could certainly try to see if we could get some roughly comparable figures. The only thing I would not want to do would be to hire an outside firm to do it.

Mrs. GREEN. I happen to know there are people in OE who do not feel BOG is a good program, so you may indeed have to conceal your disappointment. But I believe if you have a really bright person, who could be assigned this responsibility he could ignore the opposition to EOG that is so obvious in the department and come up with an objective comparison of the results of EOG and BOG—if funded at the same level.

[The following was submitted:]

EFFECT OF FUNDING SEOG PROGRAM AT $1.3 BILLION INSTEAD OF BEOG

The role of State allotments, regional panel procedures, institutional determinations and requirements for matching results in extreme variability of SEOG awards. In these circumstances, the best estimate of the result of distributing $1.3 billion through the SEOG program would be to simulate a student aid program which would make the criterion of "exceptional financial need" contained in the SEOG statute the sole criterion for both institutional allotments and individual awards.

In such a student aid program, awards would go first and in the largest amounts to those students whose need, not offset by family resources, is the greatest. Using the basic grants needs analysis system (rather than any of the other systems also employed by student aid officers), a $1.3 billion funding level would provide grants averaging a little over $2.000 to roughly 650,000 students. Less than $200 million of the total would go to students from families with incomes of less than $5,000—about half what would go to such students under the basic grant program.

The reason why low income students would receive such a small share of a $1.3 billion SEOG-type program is that SEOG treats a dollar of "need" in the same way whatever the student and whatever the college. For example, if a $20,000 income family needs $2,000 to close the gap between its expected family contribution and the cost of sending a child to a high tuition institution, that need gets the same recognition as the need of an $8,000 income family for the same amount to send a child to a State university.

FAMILY CONTRIBUTION

Mrs. Green. I regretted I could not attend the conference in Florida. I believe people from your shop did go.

Secretary Weinberger. Yes.

Mrs. Green. As I understand it, one of the conclusions reached was that the family contribution probably would be ruled out by the courts in a year's time: that 18-year-olds were full adults and, therefore, you could not demand that families contribute. If that conclusion proves true, where do you stand with BEOG?

Secretary Weinberger. We would simply have to revise the family contribution schedule. I would be surprised if the courts would adopt such a policy. They might in States such as Alabama, where a child is an adult at 14 under State law. Generally speaking, the courts would tend to follow the State laws as to what is the determination.

If the State law has determined that a child under 18 still is entitled to family support, I would be very surprised if the court would upset that, although courts frequently surprise me.

Mrs. Green. I am surprised at the courts, too, but I understand that at this conference this was one of the conclusions that was reached. And I'm not talking about students under 18. Most college students are 18 years of age and older.

Secretary Weinberger. It was one of the worries or concerns that was expressed.

Mrs. Green. When you get this bright person to do a complete study of the two programs funded at the same level you might take that into consideration—a court decision that declares 18-year-olds are full adults and families cannot be required to contribute.

Secretary Weinberger. All right.

Mrs. Green. On the basis of your allegation that BOG allows any student to attend the college of his choice, the week before last I received a letter from a mother in my district, and she returned to me the application form for BOG. The father has no income. The mother has an income of $3,050 for the entire year. They have a home, the market value of which is now $27,500, on which they owe an $8,000 mortgage. The form was sent back to them and the application for BOG money was denied. "Your family contribution that is expected is $1,953 for your daughter to go to college."

With an income of $3,050, do you think that supports your contention that BOG gives every student the choice of a college which he or she might attend?

Secretary Weinberger. The question is of eligibility. We have made substantial changes in the original family contribution schedule that was proposed last year. The family contribution schedule was approved by the Congress, I think December 20 of last year. Last year we did not even have the proposal completed until May.

There have been changes. I would doubt very much if that result would be reached with the changes that have been made this year.

Basically, the program is designed to allow qualified students eligible under the family contribution schedule to receive funds under this program in varying amounts, the maximum being $1,400, and the average, as we have said, being about $700.

That particular result that you cite obviously is a case that should not have been decided that way, and I do not believe would be under the present family contribution schedule.

Mrs. GREEN. This was November of 1973.

Secretary WEINBERGER. That would have been under last year's schedule, yes.

Mrs. GREEN. I would like to see any evidence that the BEOG program had worked any better in any other place. I fail to find it. I fail to find among the people in higher education any enthusiasm for the program.

INCREASED LIMIT ON GUARANTEED STUDENT LOANS

Mr. Secretary, you have recommended an increase in the GSL from $10,000 to $25,000.

Secretary WEINBERGER. Yes.

Mrs. GREEN. You mentioned yesterday the example of doctors, and that they would be able to repay.

Some time ago, we did a study of the $10,000 loan if a young man and a young lady each took out $10,000, the maximum, and they married and they had $20,000 in loan obligations. My recollection is that they had assumed a debt, including the interest over the repayment period, of more than $49,000.

If the Congress increases this to $25,000 so a young couple might have a $50,000 debt, and then you add the interest over the repayment period, do you think it is advisable for the Government as a matter of national policy to really be encouraging students—not all of them will be medical doctors—to encourage students to take on that kind of debt?

Secretary WEINBERGER. We are talking about a guaranteed student loan that would carry through undergraduate and graduate school. These run, as you know, 7 or 8 years. In the case of doctors, with internship and all, they run for substantial periods beyond that sometimes.

I would not say there is anything whatever that either compels or encourages anyone to take a loan in the full amount. There are, however, a few cases of people—as we mentioned earlier, we are still trying to encourage people to be trained in medical and health fields—there are a few people who might find it necessary or possible, because of the expanded limit, to get the kind of education they could not otherwise get.

It would be a substantial amount to repay, without any question. As far as the wisdom of the individual's taking it, I could not answer that. That will have to depend on his own circumstances.

We are trying to make available the opportunity for both higher education and postgraduate education for people who could not otherwise possibly afford it. I think with the tuition costs and other items the way they are these days, an increase in the outside limit is a justifiable change in the law.

Mrs. **Green**. The $10,000, of course, included graduate education, too. I ask this in connection with the default rate which has been discussed.

Secretary **Weinberger**. The default rate is much higher than we would like.

STUDENT LOAN DEFAULTS

Mrs. **Green**. What risk does the Federal Government run if we now increase the maximum amount from $10,000 to $25,000? We are really just beginning the repayment period of guaranteed loans, just barely starting it. I think what we see in default now is the very tip of the iceberg.

From 1968 through 1973—this program, as you know, is 6 years old—the OE estimates $5.8 billion have been lent to 6 million students, and through 1975 the official figure is that insured loans will total $8 billion, with $342 million in default.

This is with the repayment period barely starting. Now if Congress takes your recommendation and increases the maximum to $25,000, and couples who may not have had much study in economics or by nature are not very realistic, assume a debt of $50,000, plus interest, have you made any estimate of what the default may be?

Secretary **Weinberger**. With respect to the existing situation, we have had a default rate which has run from 5 up to 7 percent. It is now a little over 8 percent. Those are higher default rates than we like or than we want to permit to continue.

We are trying to improve the ability to collect those and not let them go or stay in default. We have asked for such things as removal of the defense of minority that has been made with respect to loans obtained by people when they are minors. Also, we have asked for additional sources to help us in the collection process.

There has not been any strong inducement on the part of lenders to try to do anything about this, nor has the Government proceeded very actively in the past because, as you say, the problem is just really coming now to be of substantial proportions.

In the case of the two people you have cited, the couple who marry, both of whom have large loans, both of them, presumably, wage earners, income producers, and both with some ability to repay these loans, we would not feel an increasing default rate because of what we believe are faulty collection provisions at the moment should deter us from trying to aid the vast majority, the 92 or the 93 percent who do not default, from getting this form of Government assistance.

The rate may increase. I hope it won't. We are trying to improve very substantially the provisions that we can take that would prevent default from occurring or continuing.

We share your concern about it, and we certainly do not want to do anything to encourage additional default.

Mrs. **Green**. The testimony before the Subcommittee on Higher Education was that the fund could be kept actuarially sound at a default rate between 1 and 1½ percent.

Secretary **Weinberger**. That would be much more tolerable than 7 or 8 percent. I could not argue with that for a moment.

Mrs. **Green**. There are many people who feel that as the default rate increases perhaps to 15 to 20 percent—the word will spread among the college students and the default rate will then go up very sharply.

To repay would be to go on the "sucker list." Do you think there is this danger?

Secretary **Weinberger**. That is why we think it is so important that word spread among the college students that the Government is not accepting defaults lightly, or is accepting a plea of minority to avoid collection or is not doing anything about pursuing people who do default. We do not believe that is a sound policy for the Government to take.

That is why we think it essential that we do establish the position that we are requesting the Congress enable us to fulfill.

Mrs. **Green**. I hope that the next administration does not justify the billions of dollars requested to repay loans that were made and have defaulted, on the basis that this administration was reckless in making this recommendation of an increase from $10,000 maximum to $25,000.

Secretary **Weinberger**. I think we do have to have some perspective about this. I think while the 7 percent default rate is much higher than any of us would like, 93 percent are not in default.

There is also a substantial number in repayment status, $3.4 billion.

Obviously, more loans are going out, and the problem may get bigger. We are taking steps that we have not taken before which we hope will reduce the default. It is a problem we are very much concerned with. It is something we do not want simply to regard as an inevitable part of this situation.

ALLIED SERVICES ACT OF 1974

Mrs. **Green**. Let me leave the student loan program.

One final question, very briefly.

On page 15, you talk about establishing the Allied Services Act of 1974.

Secretary **Weinberger**. Yes.

Mrs. **Green**. Does that cover health, education, and welfare, or is it just health?

Secretary **Weinberger**. I think it would cover all the various programs that we operate, which would certainly be in those three fields. I assume you are familiar with the basic purpose of it.

It would apply to an opportunity to the States to make this kind of consolidation ultimately across the boundary lines of the various programs that we administer.

Mrs. **Green**. Thank you very much.

Thank you, Mr. Chairman.

WELFARE REFORM

Mr. **Natcher**. Mr. Secretary, the President mentioned welfare reform in his State of the Union Message. How far have you gone in developing a legislative proposal, or what alternatives are under consideration at this time?

Secretary **Weinberger**. Mr. Chairman, we have gone only part of the way along the path the President set for us. Basically, what he wants is to have transmitted to him sometime this spring, a series of proposals and recommendations and options for him to choose among, to help him decide if he wants to submit further any of these proposals to the various other departments of the Government that would be interested in these matters, and ultimately decide then, on the basis of that, whether he wants to submit anything to the Congress.

It is in that quite preliminary stage. We are working, at his direction, on a number of different plans to replace what he believes is a very unacceptable, really lack of a system at the present time.

NEGATIVE INCOME TAX

Mr. NATCHER. You have been quoted as favoring the negative income tax. Are these reports accurate?

Secretary WEINBERGER. No, sir. I should have been quoted as saying that we are considering among other things a proposal that has some aspects of the negative income tax in it. It does have certain features that we believe would be a substantial improvement over what we have now.

We are also considering a number of other proposals. These will be wrapped up in a single memorandum to the President when we finish, hopefully sometime this spring, following which he would have a number of things he would want to do before he made any decision as to whether he submitted anything.

He feels very strongly, as you know, that what we have needs replacement; that it is not a system. He has said that many times and indicated some of the problems he has with it.

He has not, to my knowledge, made any decision, and we have not made any recommendations to him among or between these various different alternatives we are considering.

INCOME MAINTENANCE SPENDING

Mr. NATCHER. Mr. Secretary, as you and I know, Federal expenditures for income maintenance have risen rapidly in recent years. In fiscal year 1974, they went up about $11 billion, and in fiscal year 1975, they are projected to increase by another $15 billion.

Do you think there is any prospect of a leveling off of this rate of increase, with or without welfare reform?

Secretary WEINBERGER. Yes; I hope so, Mr. Chairman. I do not know if we could get it without welfare reform of some kind or welfare replacement, but I think there is some possibility of some improvement.

In 1973, for the first time since the program started we will have the aid to families with dependent children program showing an actual decline in caseload rather than the steady increase we have had every year before. It will be a fair-sized decline, somewhere in the 3 to 4 percent range. I would hope this could continue.

As you know, we have taken very substantial steps to try to improve the administration of this program and eliminate the error rate. The error rate is much too high, 41 percent, the States report to us.

We have measures under the name of the quality control program designed to produce a substantial reduction in that error rate, down to somewhere in the 3 to 5 percent range. That is beginning to take effect.

Ultimately, however, we will have to face the fact that we cannot vote substantial benefit increases each year without having the total cost of the programs, that are loosely described as income maintenance, go up, for example, an 11 percent increase in social security, a steady increase in the food stamp program, additions to the nutrition programs each year. All of these things force the total up.

The history has been that any benefit increase proposed is usually adopted, in one way or another.

FEDERAL SUPPORT TO HIGHER EDUCATION

Mr. NATCHER. Am I correct, Mr. Secretary, in thinking that the administration's strategy of Federal support to higher education is to provide student aid rather than direct institutional aid?

Secretary WEINBERGER. Basically, that is correct, Mr. Chairman.

Mr. NATCHER. Are you opposed in principle to institutional assistance, or is it simply that with limited resources you believe that student aid should have first priority?

Secretary WEINBERGER. It is the latter. I think the way you phrased it is correct. It is not that we are opposed to institutional aid as such. It is that with basically limited resources and with the goal being, for example, to help students or to train students in particular things, we think that is better accomplished if the funding goes to the student rather than to the insitution.

We are, however, using institutional aid, and we will continue to do so, in such areas as capitation grants for medical schools and things of that kind.

Basically, the thing that worries us is that if you have the institution funded and then the institution directed to go out and aid students or train students, and so on, you lose a substantial amount of the Federal funds in the form of administration, overhead, faculty salaries, and so on; where as we believe the better way to go with limited resources is to fund the student directly, either the student seeking to be especially trained in a certain field or to get postsecondary education.

RISING TUITION

Mr. NATCHER. Will this policy result in sharply rising tuition and work a hardship on the student from the middle-class family?

Secretary WEINBERGER. No. I think quite the contrary, Mr. Chairman, the policy will result in some rather healthy competition between institutions, and we may well then get an opportunity for tuition at least to level off, although, obviously, the cost has gone up very much. I do not think it would result in a steady increase in tuition rates, because I think institutions are going to have to become competitive to attract students who, under our plan, would have the control of the funds themselves.

GUARANTEED STUDENT LOAN PROGRAM

Mr. NATCHER. Are you having any second thoughts about the guaranteed student loan program now that we find ourselves having to employ quite a few bill collectors to collect defaulted loans?

Secretary WEINBERGER. No, sir. I think the fact that we did not do that before is one of the reasons we have had the default rate that Mrs. Green has quite properly called attention to.

I think the guaranteed student loan is a better way to go. The questions I have in my own mind about it relate only to better ways of administering it. I think we have to offer the lenders some clearer conviction that we are not going to delay their repayment in the event they do not get repayment directly from the students. They have to be convinced that there will not be an endless amount of Government paperwork before they can realize on the guarantee.

I would hope that through this and other means, we could encourage lenders to use the program. Basically, I think it is a better way to aid students.

BUDGET FOR BILINGUAL EDUCATION

Mr. NATCHER. The budget for bilingual education proposes $35 million, a decrease of $15 million from the 1974 appropriation. The recent Supreme Court decision in *Lau* v. *Nichols* would appear to have a significant impact on all school systems serving children with non-English-speaking backgrounds.

Why should not the Federal Government at least continue the present commitment to bilingual education?

Mr. CARLUCCI. Mr. Chairman, there is to be a hearing before the Perkins Committee on this subject on March 28, if my memory serves me correctly, at which I and Commissioner Ottina will testify. We are in the process of looking at this issue, and hope to have a position at that time.

I think it would be premature to answer this question right now.

Mr. PATTEN. Today's paper has an article about Switzerland. They really have 3 official languages—German, French, and Italian—but now they are having trouble with a group known as the Romanisch, who have a language going back 2,000 years. They may make a fourth official language.

In my town when I was a kid, many fifth graders could not speak English. They came from Hungary, Poland, Russia. We would have had to have a multilingual program, I tell you that.

Today our only problem apparently is with the Spanish, of whom we have about 8,000.

Do not make fun of the bilingual program. It has a great deal of merit.

In the Philippines, they have Spanish and English as official languages. Many countries have these language problems.

Mr. CARLUCCI. I think one of the implications of the law is that we will have to look at it in the multilingual context. In fact, the suit was brought by a person of Chinese descent. So, the issue is not really bilingual. The issue is multilingual education. It is a very complex subject.

Mr. PATTEN. How many Chinese do you have?

Secretary WEINBERGER. In San Francisco, there are quite a few.

Mr. CARLUCCI. Then you get into the question of languages for American Indian students.

Mr. PATTEN. How many Indians do we have?

Mr. CARLUCCI. About 400,000. They speak a multiplicity of languages.

HEALTH INSURANCE COVERAGE OF MENTAL HEALTH SERVICES

Mr. SHRIVER. Mr. Secretary, as you mention, the administration is proposing to include mental health services in the national health insurance program. Your plan covers up to 30 visits per year to a community mental health center. How did you arrive at this particular number of visits? What is the estimated difference in costs between covering 30 visits and providing full coverage for outpatient treatment?

Secretary WEINBERGER. I don't believe that we have any data that would pinpoint the total cost if CHIP provided unlimited coverage for outpatient visits because of the speculative nature of predicting demand in this service area.

The 30-visit standard which is provided in the mental benefit package was based upon utilization studies which show that a 30-visit benefit provision would provide complete coverage to over 90 percent of the persons receiving outpatient mental health services.

COMMUNITY MENTAL HEALTH CENTERS

Mr. SHRIVER. During the first session of this Congress, I introduced legislation designed to continue the community mental health centers program to meet the national goal of full coverage of our population by approximately 1,500 such centers by 1980. I was joined by more than 60 cosponsors on this bill, evenly divided between Republicans and Democrats in the House. It appears that this is a popular program which has proved its worth, and our bill, or one similar to it, will probably be enacted this year. I don't understand your continuing opposition to finishing this important job. Would you care to comment?

Secretary WEINBERGER. We are certainly not opposed to the development of new community mental health centers. This does not mean, however, that all communities need Federal funds to establish new centers. Because of the demonstrated success of the program, we believe that the development of alternative funding sources for new starts will no longer be as difficult as it was when the centers program represented a relatively new and experimental concept; and the Federal Government, through comprehensive health insurance, will continue to provide major financial assistance in support of these centers. Furthermore, Mr. Shriver, it is sometimes overlooked that even where the Federal Government supports community mental health centers, over an 8-year span, our support declines to 30 percent; and as far as I know, local communities are prepared to and do pick up 70 percent of the cost.

MEDICARE COVERAGE OF KIDNEY DISEASE AND HEMOPHILIA

Mr. SHRIVER. Medicare now covers treatment of chronic kidney disease. Has any consideration been given to providing similar coverage for patients, many of them children, suffering from hemophilia? There was an article recently in one of the Washington papers describing the very high costs involved in treating this disease, costs which are too high for many families.

Secretary WEINBERGER. One of the considerations in our design of national health insurance was that type of situation, Mr. Shriver, and the comprehensive health insurance proposal which we transmitted to the Congress does provide protection in the event of "catastrophic" health problems. It provides that no family would have to pay more than a maximum of $1,500 per year. This protection could apply to treatment of hemophilia.

CONTROLS ON HEALTH COSTS

Mr. SHRIVER. You mention that HEW's health financing programs would be about $500 million higher if it were not for guidelines on costs established by the Cost of Living Council. Do you have any figures as to what national health costs would be now without such guidelines?

Secretary WEINBERGER. Yes, Mr. Shriver, I do. The Cost of Living Council has estimated that total national health costs would be about $88 billion without controls and about $84 billion with controls, a $4 billion difference.

PRIOR CERTIFICATION

Mr. SHRIVER. I know you are well aware of the criticism of the proposal to require prior certification before hospital admittance for patients covered by Federal health care programs. This would work special hardships on small and rural hospitals; in fact, it would be impossible for many of them. Have you now completely withdrawn that proposal?

Secretary WEINBERGER. In view of the high costs of medical care, it makes good economic sense to have peer review prior to admission. However, many of the objections to this proposal emphasized that doctors themselves would refuse to serve on utilization review committees. To ignore this strong protest invites the situation where decisions on hospital admittance might be made by administrators rather than doctors. I have therefore decided against preadmission certification with great reluctance. I made this announcement on February 8 and extended the public commenting period to assure that there would be full consideration of these complex and important new regulations.

GUARANTEED STUDENT LOANS

Mr. SHRIVER. What are your proposals for an improved and expanded student loan program?

Secretary WEINBERGER. The administration has proposed to increase access to loan capital for all students by simplifying administration and paperwork and by making the return to lenders more attractive. Among the major points contained in the administration's bill are the following:

All loans would be unsubsidized. This would end the confusion which now exist in the minds of some lenders about eligibility for subsidy and eligibility for a loan.

For students who have great need, interest payments incurred while in school on a federally insured loan would be provided through a dollar-for-dollar increase in the size of their basic educational opportunity grant.

Lenders would be assured of a guaranteed rate of return on these loans which would take into account existing money market supply and demand conditions.

The maximum amount a student could borrow would be increased from $2,500 to $5,000 per year and from $10,000 to $25,000 for his total educational costs, while concurrently increasing the time allowed to pay back these increased loans.

The defense of being under legal age in regard to repayment of federally insured loans will be eliminated.

FORWARD FUNDING OF EDUCATION PROGRAMS

Mr. SHRIVER. You are proposing to advance fund education programs for the disadvantaged, for the handicapped, for support services, innovation, vocational education, and adult education, but not for higher education. Is that correct? Why not for higher education?

Secretary WEINBERGER. Yes, Mr. Shriver, we are proposing to forward fund the educational programs incorporated in our education grants consolidation package in order to give the States as much advance notice as possible of the amounts of Federal funding which will be made available to them. Most of the other OE programs which are tied to a school-year funding cycle are already forward funded. This includes higher education as well as some of the handicapped project grant activities, bilingual education, follow through, emergency school aid, Indian education, and several others.

STATE REGULATION OF HEALTH CARE PRICES AND CAPITAL EXPENDITURES

Mr. SHRIVER. You say you want to provide financial support to assist State efforts in regulating health care price increases and capital expenditures. Tell us more about that.

Secretary WEINBERGER. We propose to make the State level the focus for regulating health care price increases and capital expenditures. To stress the development of the State role, we will make grants to support State efforts to regulate the reimbursement for health services and the extent of capital investment in the health care system. The grants would be on the basis of a State's population and the costs of performing the functions. If the State chooses to administer both regulatory functions through one agency, it would be eligible for a bonus payment of 25 percent of its Federal payment for that year. To insure that there is an integrated relationship between the State's regulatory activities and the planning responsibilities of the Regional Health System's Agencies, the State would first obtain the recommendation of the Health Systems Agency with respect to any capital expenditure within the Agency's health service area. If the State takes action contrary to that recommendation, there must be a procedure under which its decision is reviewed by the chief executive officer of the State or his designee.

FUTURE NEEDS FOR HEALTH CARE PERSONNEL

Mr. SHRIVER. You and other witnesses keep saying we may have an oversupply of medical care personnel if we continue present training programs. Would you provide information for the record to back up this prediction? Break that information down by the existing categorical training programs, for example, for nursing, allied health, et cetera.

Secretary WEINBERGER. Our projections of oversupplies of medical personnel are based, primarily, on continuation of the current programs of Federal support, which place a major emphasis on increasing enrollments and outputs. It is the continuation of this expanding enrollment which, if unchecked, could result in an oversupply of medical personnel and probably still not provide satisfactory geographic and specialty distribution.

The federally aided expansion of enrollment growth that began during the latter 1960's is just now beginning to be reflected in sharp increases in the supply of active practitioners. A maintenance of recent enrollment levels, furthermore, virtually assures rapid increases in the Nation's supply of health professionals in the coming years.

As seen in the table that I would like to supply for the record, the supply of active physicians, dentists, optometrists, pharmacists, podiatrists, veterinarians, and registered nurses is projected to increase substantially over the next two decades, with corresponding increases in the number of practitioners per 100,000 population. Taken together, the supply of these groups is projected to grow from 1,329,100 in 1970 to somewhere between 1,849,400 and 1,885,600 by 1980, and between 2,388,800, and 2,484,600 by 1990. As a result of this substantial increase, the ratio of active health professionals to the total resident population is also projected to rise rapidly. In 1970, there were a total of 652 health professionals for each 100,000 population; the ratio is projected to reach 815–831 per 100,000 by 1980 and 953–991 per 100,000 by 1990

These projections assume that the number of first-year places mandated by Federal legislation provisions existing at the end of 1972 would be maintained through academic year 1974–75, and that upon the expiration of current legislation in fiscal year 1974, a combination of both public and private support would be available to at least maintain the productive capacity of schools needed to insure the level of professional school enrollment resulting from these acts.

[The information follows:]

SUPPLY OF SELECTED ACTIVE HEALTH PROFESSIONALS: ACTUAL 1970; PROJECTED 1980 AND 1990

Profession	Actual 1970	Projected 1980	Projected 1990
NUMBER OF ACTIVE PERSONNEL			
Total	1, 329, 100	1, 849, 400–1, 885, 600	2, 388, 800–2, 484, 600
Physicians (M.D. and D.O.)	323, 200	435, 000–447, 000	554, 000–594, 000
Dentists	102, 200	126, 200	154, 900
Optometrists	18, 400	21, 700–21, 800	25, 300–28, 000
Pharmacists	129, 300	145, 600–146, 100	171, 800–179, 900
Podiatrists	7, 100	8, 500	10, 900–13, 000
Veterinarians	25, 900	36, 300–36, 400	45, 700–48, 100
Registered nurses	723, 000	1, 076, 100–1, 099, 600	1, 426, 200–1, 466, 700
RATE PER 100,000 POPULATION			
Total	652. 1	815. 0–830. 9	953. 1–991. 3
Physicians (M.D. and D.O.)	158. 6	191. 7–197. 0	221. 0–237. 0
Dentists	50. 2	55. 6	61. 8
Optometrists	9. 0	9. 6	10. 1–11. 2
Pharmacists	63. 4	64. 2–64. 4	68. 5–71. 8
Podiatrists	3. 5	3. 7	4. 3–5. 2
Veterinarians	12. 7	16. 0	18. 2–19. 2
Registered nurses	354. 8	474. 2–484. 5	569. 0–585. 2

Note: Rates may not add to totals due to independent rounding.

Source: Resource Analysis Staff, BHRD, HRA, DHEW.

HEROIN ADDICTION

Mr. SHRIVER. You say we have now gotten through the worst of the heroin addiction crisis. We are glad to hear that, of course, on what information have you based that conclusion?

Secretary WEINBERGER. A number of indicators support the conslusion that the recent national trend of increasing heroin addiction has been halted. During the period of 1966–73, a study was made on patients admitted for treatment of heroin abuse for the first time at reporting clinical facilities in 32 indicator communities. Those who used the drug for the first time dropped from 1,583 in 1969 to 830 in 1971, and to 115 in 1973. Second, the Drug Enforcement Agency reports heroin-related deaths have declined significantly, with 24 cities in the United States reporting a total of 51 during the second quarter of fiscal year 1973, 15 during the third, and 14 during the fourth. Finally, the Drug Enforcement Agency's Drug Enforcement Statistical Report on 25 selected cities reports fewer addicts on June 30, 1973, than in the previous year.

TAKING IMPACTED AREA AID INTO ACCOUNT UNDER STATE EQUALIZATION PLAN

Mr. SHRIVER. Mr. Secretary, included in H.R. 69 as reported by the Education and Labor Committee of the House is a provision allowing States to take Public Law 874 impact aid funds into account in the distribution of State aid under an equalization formula. Are you familiar with that provision?

Questions have come up in my own State of Kansas, which has an equalization plan in effect, as to the possible interpretation you would give to language in the committee report concerning this provision. One of the criteria you are to use in determining whether a State's educational finance program is equalizing is whether the State's funds are being apportioned with allowances "for the necessary variations in costs per unit of educational need." This would seem to be difficult to apply. How do you determine "the necessary variations in costs per unit of educational need?"

Second, while the language in the bill seems plain that States shall be allowed to count these impact aid funds, the report states that you are to consider the portion of total education budget of local school districts which is furnished by the States, and that then to prescribe an equivalent ratio for each State's determination in considering impact aid payments as local resources. In Kansas, for instance, the State pays approximately 40 percent of the overall budgets of local school districts. If they are only allowed to consider 40 percent of the impact aid funds going into the impacted districts in setting their fund levels, three school districts would have more revenue than they could spend lawfully (because of a Kansas law limiting annual spending increases), and they would have to have no general fund mill levy. Would this be your interpretation of this report language?

If this situation is to be corrected, would you consider it necessary to amend the language of the bill to read that the "total amount" of impact aid payments shall be considered in setting funding levels of State aid under equalization plans?

Secretary WEINBERGER. As you may be aware, the administration has supported a straight repeal of section 5(d)(2) of Public Law 81-874 because States like Kansas are moving on their own to develop and implement so-called equalization laws. We are encouraged by this trend and would like to support such moves by States by repealing section 5(d)(2). However, we have opposed wording which ties repeal of section 5(d)(2) to a determination by the Department of the adequacy of State equalization formula. We continue to oppose such language precisely because it raises for us many of the questions you have asked. At this time, we are not in a position to make judgments about the effectiveness and efficiency of various State equalization laws. Further, we have not yet analyzed how we would or if we could implement the current provisions of H.R. 69. Therefore, we would recommend that H.R. 69 be amended to repeal section 5(d)(2) alone without the additional requirements of section 304. We recommend instead language which would strike section 5(d)(2) of Public Law 81-874.

Mr. NATCHER. Mr. Conte?

NIH BUDGET

Mr. CONTE. Thank you, Mr. Chairman. The 1975 budget proposes to "hold steady" at the dollar level a number of major programs—for instance all of the NIH institutes except cancer and heart. If you want to "hold steady" at the program level, how much would you have to figure in to cover inflation in the past year?

Secretary WEINBERGER. I would guess that the rate of inflation has been in the neighborhood of 6 percent, Mr. Conte. But, while the dollar levels for the NIH research institutes other than cancer and heart are the same as 1974, I should like to point out that the actual funding of regular research grants in 1975 will be about 15-percent higher than in 1974. This is because we have not provided funds for new training grants but have used the savings to provide additional funding for research grants.

REVISION OF BUDGET ESTIMATES TO REFLECT CHANGED ECONOMIC CONDITIONS

Mr. CONTE. Your statement, and the HEW budget, has no reflection of either the energy crisis or related rising unemployment. Are you ready, or are you preparing, to revise any program estimates in light of the general employment situation?

Secretary WEINBERGER. No assumptions were specifically built into the 1975 budget in an attempt to guess at what the economic impact of the energy crisis would be; although, we do know that a continuation of the crisis should have an impact. The largest impact should be felt in the income security programs where benefit and recipient levels are related to changing employment and price conditions. In other HEW programs, price fluctuations because of the supply of energy sources is a lesser problem—fuel allocations themselves are the crucial factor.

We are not prepared at this time to propose any changes in program estimates because of the energy crisis, though, Mr. Conte. We simply don't have enough data.

SETTING PRIORITIES IN MEDICAL RESEARCH

Mr. CONTE. Few of us question the need for you to set priorities, but, as you know from last year, there's a lot of questions about setting research priorities by disease. Do you see any alternative kinds of priorities in biomedical research?

Secretary WEINBERGER. There are a number of scientific disciplines which undergird many of the disease categories. Some of the more familiar of these disciplines are: Genetics, immunology, virology, molecular biology, cytology, as well as the classical medical school departments of anatomy, biochemistry, physiology, pharmacology, microbiology, and pathology. Certainly on occasion it is useful to establish priorities within some areas of biomedical sciences in these terms rather than in terms of diseases or of organ systems. However, except in the rarest of instances, we ask the NIH to establish those priorities. I assure you that I personally do not attempt to make those kinds of choices.

CUT IN MENTAL HEALTH RESEARCH

Mr. CONTE. One research item cut, rather than held steady, is general mental health research. Where is the cut and what will its effect be?

Secretary WEINBERGER. The 1975 mental health research budget was reduced about $5.5 million below the 1974 appropriation. About $1 million of this reduction is in the hospial improvement program which we are proposing to phase out. The balance of the reduction is in the regular research program. The total level provided permits the funding of ongoing continuation projects as well as a substantial number of current projects up for competitive renewal. We do expect to realize some margin for new projects within these continuation and competing project funds. However, we are taking another look at the adequacy of the 1975 proposed funding level for mental health research in order to determine whether some adjustments should be proposed.

NEED FOR INFORMATION ON STUDENT LOAN DEFAULTS

Mr. CONTE. On guaranteed student loan defaults, I want to make a point I raised at the hearing on the supplemental request. No effort has been made to collect information on the kinds of students defaulting—whether they're employed or unemployed, family income, and so forth. At the very least, collectors should be required to get simple information for use in evaluating the program.

Secretary WEINBERGER. A considerable amount of information is obtained at the time that a student applies for a loan, including data on age, race, sex, marital status, parental gross and adjusted gross income, lender source, and educational institution attended. There is no information, however, on his own income and employment after he has graduated or otherwise left school. The Office of Education is planning to survey approximately 8,000 borrowers who are currently in repayment status and who are, therefore, either currently repaying or defaulting on their loans. By analyzing responses to the survey questions, we expect to be able to generalize about the employment and income characteristics of the entire population of 137,000 defaulters and thus to be able to draw a rather definitive "profile" of the characteristics of such defaulters. Preliminary data from this survey should be available by September 30, 1974.

AVAILABILITY OF MENTAL HEALTH SERVICES

Mr. Conte. I was pleased to see the inclusion of mental health services in the President's health insurance plan. And I think looking to health insurance plans to make access to those services more equitable is valid. But I'm concerned we aren't going to have the services available to make that insurance coverage realistic. Will you comment on this?

Secretary Weinberger. This is a very difficult question to answer, Mr. Conte. I think that it would be natural to expect an increase in demand for services if financing becomes more widely available, as would occur with the passage of our Chip proposal. If past experience is any guide, though, the supply of medical and other mental health professionals and technicians should be elastic enough to meet increased demand without the need for any special Federal intervention. But, of course, nobody is that certain what will happen and it is a situation that will require close monitoring in order to be sure that major problems do not occur.

POSSIBLE SURPLUS OF HEALTH MANPOWER

Mr. Conte. Are there any health manpower projections—taking into account probable enactment of National Health Insurance and actual enactment of HMO legislation—that show manpower surpluses in any specific fields in the next few years?

Secretary Weinberger. We have no current data which indicate the surpluses of health personnel will exist in the immediate future, that is the next 2 or 3 years. What we are saying, however, is that if enrollment levels of health training institutions continue to increase, as they have over the past 5 or 10 years, there is a distinct possibility that a surplus situation would develop. If present training programs maintain current enrollment levels, the Nation's supply of medical and health personnel is projected to grow substantially in the coming years. This increase will be much more rapid than the growth in population.

CONCLUDING REMARKS BY CHAIRMAN

Mr. Natcher. Mr. Secretary, on behalf of the members of our subcommittee, I want to thank you for an excellent presentation of your budget request for fiscal year 1975. On this subcommittee we have always found that your associates, Mr. Carlucci and these other fine ladies and gentlemen that you have with you this morning, and Mr. Miller, who sits with us day after day, have all been very helpful in solving all the matters pertaining to your budget.

As you know, the Labor-HEW appropriations bill that we now have before our committee affects every man, woman, and child in this country. I am sure that you will agree with me that our common goal is to work out a bill which is responsive to their needs, which we all can support, and which can be enacted without undue delay.

Mr. Secretary, I know we can depend upon your assistance throughout the hearings on this bill, and also on the members of your staff.

Again, on behalf of the committee, I want to thank you and your associates for an excellent presentation.

Secretary **Weinberger**. Thank you very much, Mr. Chairman. We have greatly appreciated the courtesy and the skill with which this hearing has been conducted, and the penetrating nature of the questions. It has been a very pleasant experience for me and, I am sure, for my associates, to have been here.

We certainly share your goals and will do everything we can to help you reach them.

Mr. **Natcher**. Thank you, Mr. Secretary.

We will place in the record the usual comprehensive statements regarding the Department's activities in various fields.

[The comprehensive statements follow:]

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COORDINATION OF MENTAL RETARDATION PROGRAMS

The thrust of the Federal commitment in combating mental retardation depends upon a highly coordinated interagency effort. Coordination is vitally important in administering the many varied and diverse programs serving the retarded. It is a fact that mental retardation cannot be confined to any single health, education, rehabilitation or welfare program, or any one disciplinary group. A coordinated program, therefore, must provide a broad spectrum of activities designed to attack the problem of mental retardation wherever it touches the lives of people.

During Fiscal Year 1974, an estimated $1.6 billion will be obligated by the Department of Health, Education, and Welfare for mental retardation programs. These programs cover most aspects of the retarded person's life. They range in diversity from maternal and infant care to income maintenance for the aged retarded. Many agencies of the Department administer programs which affect the mentally retarded; it is extremely important that these efforts be focused and targeted so as to prevent duplication and gaps in program services.

The 1962 Report of the President's Panel on Mental Retardation recognized the importance of coordination both at the national and local levels. The Report further endorsed the concept of a Departmental committee composed of agency representatives advising the Secretary on activities related to mental retardation. The concern of the Panel resulted in the strengthening of the Secretary's Committee on Mental Retardation in 1963. The Committee had previously been known as the Departmental Committee on Mental Retardation, since its establishment in March of 1955.

Over the next several years the mental retardation program of the Department was expanded and extended. In 1968, in a move designed to make the Secretary's Committee more responsive to prevailing needs, the Secretary reconstituted the membership of the Committee to include the top level executives of the Department with the Under Secretary serving as Chairman. In addition, Regional Office Staff were also assigned to coordinate mental retardation Regional activities.

The mission of the reconstituted Secretary's Committee on Mental Retardation remained the same; i.e., the responsibility for coordination of the Department's programs and activities affecting the mentally retarded.

On January 25, 1972, the Secretary of Health, Education, and Welfare directed the establishment of the Office of Mental Retardation Coordination. This new unit replaced the Secretary's Committee on Mental Retardation and is responsible for the duties formerly assumed by that Office. Specifically, the Office of Mental Retardation Coordination is responsible for the following activities:

- Serves as a means of coordination and evaluation of the Department's mental retardation activities.
- Serves as a focal point for consideration of Department-wide policies, programs, procedures, activities and related matters relevant to mental retardation.
- Serves in an advisory capacity to the Secretary in regard to issues related to the administration of the Department's mental retardation programs.
- Serves as liaison for the Department with the President's Committee on Mental Retardation.

There are two coordinating committees under the Office of Mental Retardation Coordination: Steering Committee: Consists of representatives of the Office of the Assistant Secretary for Health, Social and Rehabilitation Service, Health Services Administration, National Institutes of Health, and the Office of Education. This group is responsible for advice and consultation in the implementation of the Office functions. Mental Retardation Interagency Committee: Consists of representatives of all mental retardation operating programs. Its functions are to provide a means of communication, information exchange and program development for agency staff concerned with Federal mental retardation activities.

The Office of Mental Retardation Coordination places special emphasis on coordination and implementation of the President's proposals to reduce mental retardation, and to minister more effectively to those affected by this problem. OMRC evaluates the impact that the Department's mental retardation programs have on the mentally retarded in local communities, and each Regional Office is served by a mental retardation coordinator, located in the Office of the Assistant Regional Director for Human Development. The development of local volunteer programs for the mentally retarded and of programs for the deaf-blind-retarded is given special focus.

The Office of Mental Retardation Coordination maintains a distribution list of over 12,000 names of persons and organizations which receive publications distributed by this Office and agency publications in the area of mental retardation. The Office of Mental Retardation Coordination has also represented the Department at national meetings of the American Association on Mental Deficiency, the National Association for Retarded Citizens, the Council on Exceptional Children, United Cerebral Palsy Association, and the Association for Children with Learning Disabilities. Publications and information were provided by Office staff to delegates during these meetings.

SUMMARY OF MENTAL RETARDATION ACTIVITIES

The mental retardation activities of the Department have been arranged according to the following categories: preventive services, basic and supportive services, training of personnel, research, construction, and income maintenance.

Preventive Services

Most States have enacted laws related to phenylketonuria (PKU) and make screening for this disorder mandatory. Throughout the country approximately 90 percent of the total registered live births are being screened.

Basic and Supportive Services

Basic and supportive services are defined as those services rendered to or for persons who are mentally retarded.

State health departments and crippled children's agencies use funds administered by the Maternal and Child Health Services for programs designed to: increase the health and welfare services available to the retarded, enlarge existing mental retardation clinics by adding clinic staff, increase the number of clinics, extend screening programs, provide treatment services for physically handicapped retarded youngsters, increase inservice training opportunities, and provide other care services for the mentally retarded.

The mentally retarded receive a variety of services through the vocational rehabilitation program supported by the Rehabilitation Services Administration: medical diagnosis, physical restoration, counseling and testing during the rehabilitation process, assistance in job placement and follow-up to insure successful rehabilitation.

The Health Services Administration, in conjunction with the Division of Developmental Disabilities, Rehabilitation Services Administration, Social and Rehabilitation Service, supports projects for the retarded which have service components of well-integrated comprehensive health and mental health programs.

The Division of Developmental Disabilities supports two programs directed at improving the quality of State institutional care and treatment for the mentally retarded. These programs are the Hospital Improvement and Hospital Inservice Training Programs.

The Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (P.L. 88-164) was amended October 30, 1970, by the Developmental Disabilities Services and Facilities Construction Act of 1970 (P.L. 91-517). The new Act was designed to provide the states with broad responsibility for planning and implementing a comprehensive program of services and to offer local communities a strong voice in determining needs, establishing priorities, and developing a system for delivering services. The scope of the present program broadened to include not only the mentally retarded but also persons suffering from other serious developmental disabilities originating in childhood, including cerebral palsy, epilepsy and other neurologically handicapping conditions. On December 28, 1971, the Division of Developmental Disabilities issued proposed regulations for the administration of this Act.

With the enactment of the Elementary and Secondary Education Act of 1965 (P.L. 89-10) and its subsequent amendments has come a number of new programs and services for the mentally retarded. The mentally retarded have especially benefitted from the provisions of Title VI of the aforementioned act, which provides opportunities for local school districts to develop new and creative programs for all handicapped children. The amendments of 1969 (P.L. 91-230), signed into law April 13, 1970, consolidated all legislation relating to education of handicapped children in Title VI. The Bureau of Education for the Handicapped in the Office of Education administers Title VI, which is now referred to as "The Education of the Handicapped Act."

Training of Personnel

Training programs form an integral part of most of the mental retardation programs of the Department. These programs include support of professional preparation in the following areas: research training in the basic and clinical biological, medical and behavioral sciences; training of professional personnel for the provision of health, social and rehabilitative services for the mentally retarded; inservice training of workers in institutions for the mentally retarded; teachers and other education personnel related to the education of mentally retarded children; and training of personnel in physical education and recreation for the mentally retarded and other handicapped children.

Research

The National Institute of Child Health and Human Development in the National Institutes of Health will support mental retardation research and research training grants to an estimated amount of over $18 million in fiscal year 1974. The National Institute of Neurological Diseases and Stroke, the National Institute of Arthritis and Metabolic Diseases, among other Institutes of the National Institutes of Health, also contribute to mental retardation research. These contributions directly or indirectly extend the efforts of the Mental Retardation Branch of the National Institute of Child Health and Human Development.

The Division of Research in the Bureau of Education for the Handicapped of the Office of Education now supports six Research and Development Centers to focus on the more difficult problems of evaluation, communication, instructional procedures, etc. of handicapped children. Through the combined efforts of Research and Development Centers and programmatic research, definite improvement in instructional procedures may well be realized within the next several years. New systems of dissemination are being built upon the foundations already developed by the Instructional Media Centers and a system of Regional Resource Centers currently being developed. As more funds for research become available, engineering technology will more and more become a part of research supported by this Division. This development has been made possible by the amendment permitting the use of contracts as well as grants for research and development activities. Engineering technology, programmed instruction, and the "systems approach" to education will occupy a major place in the Division's activities in the years to come.

The Rehabilitation Research Branch Program of the Division of Research and Demonstrations of the Social and Rehabilitation Service supports a substantial program of research on problems of rehabilitation of retardates. Areas covered include evaluation of aptitudes and abilities, analysis of jobs which the retarded can perform, opening of new occupational areas for the retarded, improvement of counseling techniques, development of new methods of training and job adjustment and evaluation of facilities and programs to assist the transition of the retardate from the institution to community participation. Current programs of research and demonstration are increasingly concerned with new approaches to retardation in ghetto areas. Emphasis is placed on the coordination and focusing of all relevant community agencies on the problems of the retarded. The Research and Training Centers Division continues to sponsor three Mental Retardation Research and Training Centers. They are continuing to seek out the cause of mental retardation, to assess the potential for education and rehabilitation, to develop training and remedial programs, to ascertain their actual learning and socialization difficulties, and to develop methods to more adequately motivate the retarded for work.

Research grants administered by the Maternal and Child Health Service support projects directed toward the evaluation of programs and improving the development, management and effectiveness of maternal and child health and crippled children's services. Some examples of support include studies of the epidemiology of mental retardation in a rural county, sensory integrative processes and learning disorders, children with congenital rubella, perinatal casualty reports, galactosemia screening, and sensory motor activity in the neurologically handicapped child.

Construction

The university-affiliated facility construction program is administered by the Division of Developmental Disabilities, Rehabilitation Services Administration, Social and Rehabilitation Service.

This construction program is authorized under P.L. 91-517, the Developmental Disabilities Services and Construction Act of 1970, which supplants in part and expands the old mental retardation law of 1963 to allow for grants to States for planning, construction, administration, and services for the mentally retarded, cerebral palsied, epileptic, and other neurologically disabled individuals. University-affiliated grants are made also to cover the costs of administration and operation of facilities and for the training of physicians and other professional personnel vitally needed to work with the mentally retarded.

Continuing progress is being made in developing projects for the construction of community facilities for the mentally retarded in widely scattered areas throughout the country. Facilities constructed under this legislation are designed to provide diagnosis, treatment, education, training or care for the mentally retarded, including sheltered workshops.

Income Maintenance

The Social Security Administration administers a program which contributes to the maintenance of the mentally retarded through the payment of monthly benefits to eligible individuals.

In January 1974 the Social Security Administration added a new program, Supplemental Security Income (SSI), to provide payments to qualified aged, disabled, and blind persons, including the mentally retarded. Under Title XVI, an estimated 227,000 retarded individuals who are not entitled to Title II benefits will be receiving payment under the SSI program by the end of fiscal year 1974.

OFFICE OF HUMAN DEVELOPMENT

Office of Child Development

Mental Retardation

In July 1969, the Office of Child Development (OCD) was established in the Office of the Secretary of HEW to serve as a point of coordination for Federal programs for children and their families and to act as a national advocate of services for children. On April 1, 1973, OCD became a part of a new Office of Human Development in HEW which focuses on groups of Americans with special needs.

OCD's concerns extend to all children from conception through early adolescence, with emphasis on the formative five years of life and on children who are "at risk" because they have special problems. There are two bureaus in OCD: The Children's Bureau, which provides a wide range of technical assistance services relating to programs for children and families, and the Bureau of Child Development Services, which operates Head Start and other innovative early childhood programs.

While OCD does not directly operate any programs for the mentally retarded, the agency has an overall advocacy and leadership responsibility for all children, including children with mental retardation. In line with this responsibility, the Office of Child Development may help plan and recommend programs to deal with mental retardation; develop standards and guidelines for such programs; and provide technical assistance to States and public and private agencies in efforts to help mentally retarded children and youth. OCD works cooperatively with the President's Committee on Mental Retardation, the Office of Mental Retardation Coordination, the SRS Division of Developmental Disabilities, and other HEW agencies.

A. Children's Bureau

Children At Risk

In FY 1974, the Office of Child Development will focus its research and demonstration grant activities on two sub-populations of children at risk: children with physical and mental handicaps and children removed from public residential care institutions and returned to the community/home setting. For both these groups of children, the overriding issue is ensuring the child's opportunities for a healthy and enduring experience with family or community life.

Specifically, OCD will fund grants: (a) to demonstrate effective methods of recruiting adoptive parents for handicapped children through collaborative efforts between national voluntary agencies serving the handicapped and State or local social service departments; and (b) to assess deinstitutionalization processes utilized by State and local public institutions and the effects of these deinstitutionalization processes on children's welfare for the purpose of developing effective program models in subsequent years.

Project on Classification of Exceptional Children

OCD is serving as lead agency for an HEW study of appropriate and inappropriate classification of children as physically handicapped, mentally retarded, emotionally disturbed, delinquent, or culturally deprived. Funded by OCD, OE, NIMH, NICHD, and SRS, the $369,000 Project on Classification of Exceptional Children grew out of the Secretary's concern for the way children were "labeled" by health, judicial, social, educational, mental health and other agencies for administrative purposes, frequently in a manner detrimental to children and their families.

Dr. Nicholas Hobbs at Vanderbilt University has organized a national advisory committee, with 30 subcommittees throughout the country to assist his staff in examining the sociological, legal, and administrative bases for classification and the effects on children and families. In the Spring of 1974, a collection of reports will be issued with policy recommendations for national, state and local public and private agencies, courts, clinics, etc. Liaison with Federal agencies is maintained through an HEW Interagency Task Force.

Parenthood Education for Handicapped Teenagers

In the Fall of 1972, the Office of Child Development and the Office of Education launched a joint nationwide program called Education for Parenthood. The program is designed to prepare teenagers for parenthood by providing them with instruction in child development and an opportunity to work with young children.

As part of the overall program, OCD awarded a grant for the development of a new work/study curriculum, called "Exploring Childhood," which is now being tested in 226 junior and senior high schools across the country. OCD and OE's Bureau of Education for the Handicapped are currently developing plans for adaptation of the curriculum for use by handicapped adolescents, including the mentally retarded. Curriculum development and testing are expected to take place in FY 1975.

B. OCD Cooperative Affiliations

(1) OCD participates as a member of the Mental Retardation Interagency Committee chaired by Wallace Babington, Director, Office of Mental Retardation Coordination

(2) OCD is a member of the Board of Advisors for an SRS (Division of Developmental Disabilities) project implemented by the National Association of Private Residential Facilities for the Mentally Retarded, which is gathering comprehensive service data provided by private residential facilities for the mentally retarded.

(3) OCD provides consultation to SRS-Medical Services Administration in its development of Standards for Payment for Intermediate Care Facility Services in Institutions for the Mentally Retarded, under provisions of Title XIX of the Social Security Act.

(4) OCD provides consultation to SRS, Development Disabilities Division, in development of forward plans for deinstitutionalization of care for mentally retarded children, and upgrading care for those children who still need residential care.

(5) OCD brought together various HEW agencies on the subject of childhood autism, the need for clarification of programmatic responsibilities, and the need for collaboration.

C. Head Start

Head Start enrollment has always been open to handicapped children, but greater emphasis is now being placed on their needs. Project Head Start is in the process of carrying out a mandate contained in the 1972 Amendments to the Economic Opportunity Act which requires that at least 10% of Head Start's national enrollment consist of handicapped children, including those who are mentally retarded, Enrollment of the handicapped has risen from 17,000 in 1972 to about 37,000 in 1973. Head Start staff members are now receiving special training in working with handicapped children. The handicapped receive the full range of Head Start services as well as special health and education services provided by appropriate agencies in the community.

In addition, 14 experimental projects have been launched to demonstrate new ways of serving handicapped children in Head Start. Six of these projects are early childhood projects jointly funded by OCD and the Bureau of Education for the Handicapped in the Office of Education, and eight are operated by Head Start programs. The projects will develop a variety of approaches for integrating handicapped and non-handicapped children in Head Start programs. The integration of handicapped children in Head Start is viewed as a valuable experience for all the children concerned since it will help them learn to understand and respect human differences.

10

OFFICE OF EDUCATION

Report on Mental Retardation
(FY 1975)

Programs dealing with handicapped children in the Office of Education have been placed under the administrative direction of the Bureau of Education for the Handicapped. This is consistent with the efforts of the Office of Education to provide maximum educational programming for all children. The organization is responsible for supervising and implementing current and new legislative authorities to provide funds for projects and programs relating to the education and training of and research on handicapped children and youth. These children include those who are mentally retarded as well as those who are hardof hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, crippled, or other health impaired and require special education.

The overarching goal for Federal efforts in the area of education for the handicapped is to equalize educational opportunities for handicapped children. Less than 40 percent of the nation's more than six million school-aged handicapped children receive needed special education services.

The main issues surrounding the Federal role in education for the handicapped are:

1. How can the limited available Federal resources be used in a catalytic and stimulative manner to bring quality educational services to the greatest proportion possible of the unserved 60 percent of the target group?

2. What is the best use of Federal resources in preventing identifiable handicaps from becoming serious disabilities in school and adult life?

3. What educational techniques and methods can be developed, introduced and adopted to insure handicapped children job skills to enter adulthood with a high probability of participating in society in a meaningful manner?

Five objectives have been adopted for the Federal programs for education of the handicapped:

I. National Commitment

To assure that every handicapped child is receiving an appropriately designed education by 1980 (75% by 1977).

II. Increased Services

To assist the States in providing the appropriate educational services to 75% of the handicapped by 1977.

III. Career Education

To assure that by the year 1977, every handicapped child who leaves school has had career educational training that is relevant to the job market, meaningful to his career aspirations, and capable of bringing him up to his fullest potential.

IV. Manpower Development

To assure that all handicapped children served in the schools (75% by 1977) have a trained teacher competent in the skills required to aid the child in reaching his full potential.

V. Early Childhood Education

To secure the enrollment of 750,000 (75%) preschool aged handicapped children in Federal, State, and local educational and day care programs.

In order to efficiently implement the program and carry out the Federal mandate, the Bureau is administratively organized into three major divisions under the Office of the Associate Commissioner. Each of the major Divisions -- Training, Educational Services, and Research -- functions as an integral element in the total Bureau program for handicapped children. The following pages describe the functioning of each division as it relates specifically to mentally retarded children.

A. Purpose

The Division of Personnel Preparation initiates, maintains, and improves programs for the preparation of professional leadership and teaching personnel to educate handicapped children. Divisional programs which are designed to implement this purpose are two-fold in their attack, in that they must provide: (1) classroom supervisory, consultative, and administrative personnel for State and local special education programs; and (2) personnel for higher education institutions responsible for preparing administrative and classroom personnel.

B. Need

As more States legislate mandatory education for handicapped children the major problem faced in implementing such legislation is an acute shortage of qualified personnel. According to data received from the State Plans submitted by State education agencies under Part B, Education of the Handicapped Act, for fiscal year 1972 approximately 484,000 teachers and other personnel were needed to provide educational services to all handicapped children. Approximately 115,000 or 24 percent of the preceding personnel were needed in the area of mental retardation. Still, only 73,400 or 64 percent of the latter number needed for the education of the mentally retarded were employed in 1972 and many of these persons lacked full certification. If general turnover rates applicable to the education profession are applied, approximately 8 percent of the special education teachers will leave the field each year. At current rates of preparing professional personnel in mental retardation more than twenty years will be needed to close the gap between supply and demand, if all other variables remain constant.

Partially as a result of the teacher shortage, approximately 40% of the more than six million handicapped children of school age and one million handicapped children of preschool age are not receiving the special educational services they require. Many of the established programs are actually of minimal quality, because they have been started with less than fully qualified personnel. This current deficit, as in the past, not only retards the systematic growth of special education, but simultaneously requires the majority of our nation's handicapped children to accept an education program inappropriate to their needs. Similarly, college and university personnel so essential to the preparation of teachers are also in short supply.

C. History

In 1958, Public Law 85-926 was passed by Congress authorizing an appropriation of $1 million per year for the preparation of professional personnel in the education

[12] of the mentally retarded. This initial piece of legislation was directed at preparing college and university personnel to staff the then existing programs, and much needed new programs for preparing personnel to work with the handicapped in State and local school systems. Between academic years 1959-60 and 1963-64, 692 graduate traineeships were granted to 484 individuals. The majority of these individuals became college and university professors while others became State and local special education leadership personnel. In fact, a recent survey made of the above traineeship recipients indicated that approximately 75 percent of all programs in mental retardation at colleges and universities are directed or coordinated by these individuals.

A study conducted in February of 1964, of 245 former P.L. 85-926 traineeship recipients revealed that over 90 percent of them were engaged in the field of special education, including the mentally retarded, and about 70 percent were engaged primarily in the field of mental retardation. Sixty-eight of the 245 former trainees indicated that they were currently employed by a college or university, 80 were employed in an administrative or supervisory capacity (19 of these were employed by State educational agencies), and 54 returned to the classroom as teachers of the mentally retarded.

On October 31, 1963, P.L. 88-164 was signed into law. Section 301 of this Act amended P.L. 85-926 to: (1) expand the program to include not just the area of mental retardation, but also the areas of the visually handicapped, deaf, crippled and other health impaired, speech and hearing impaired and the emotionally disturbed: (2) allow for the preparation of teachers and other specialists in addition to leadership personnel at the graduate level; (3) extension downward into the senior year undergraduate levels; and (4) increase the monies authorized for these purposes.

Public Law 85-926 was further amended with the passage of Public Law 89-105 and 90-170. These amendments expanded and extended the program through fiscal year 1970, authorizing appropriations of $29.5 million for fiscal year 1967; $34 million for fiscal year 1968; $37.5 million for fiscal year 1969; and $55 million for fiscal year 1970. On April 13, 1970, Public Law 91-230 was signed into law, effective June 30, 1970. Title VI of this law consolidates all of the prior legislation relating to the handicapped children which the Bureau of Education for the Handicapped administers. Title VI of Public Law 91-230 is referred to as "The Education of the Handicapped Act."

These appropriated funds have been used as stipends for students as well as to support colleges, universities, and State education agencies. Since P.L. 85-926 was passed in 1958, approximately 31,000 traineeships have been awarded to individuals preparing to work with mentally handicapped children. This includes both short-term and full academic year awards.

Table I - Awards made in the area of mental retardation since the passage of P.L. 85-926 (Fiscal Years 1960 through 1972)

Fiscal Year	Number of Traineeships	Number of Higher Education Institutions Participating	Number of State Education Agencies Participating	Total Amount Obligated
1960	177	16	23	$ 965,222
1961	164	18	41	993,433
1962	160	20	46	997,000
1963	163	19	48	996,433
1964	2,357	108	50	6,419,332
1965	2,506	153	50	6,569,815
1966	3,110	162	52	7,658,002
1967	3,816	177	53	8,891,072
1968	4,521	177	53	8,493,668
1969	6,366	193	53	9,382,084
1970	6,171	200	55	10,391,341
1971**	4,909	207	55	8,955,355
1972**	5,100	210	56	8,955,355

**Although it appears that the number of trainees and amount of money expended have been reduced, the decrease in actuality reflects the changing focus of our award program. Approximately $4 million was granted to 16 universities for fiscal year 1971 as program support grants rather than the traditional traineeship grants. Undoubtedly, a high percentage of that money, and a large number of personnel trained were in the area of mental retardation. For fiscal year 1972, the Training Division moved completely to Program Assistance Grants. While our expectations are that the number of trainees benefitting from grants and graduating from programs will be substantially increased, it will become impossible to describe our program in terms of the number of trainees directly supported, or to delineate all trainees according to distinct areas of the handicapped. In addition, the area of interrelated handicapping conditions has received significant support. Interrelated handicapping conditions generally cover marginal handicaps (mentally retarded, emotionally disturbed, and learning disabled children).

It is readily apparent that the "old" P.L. 85-926 program, and its major amendment, P.L. 88-164, have enabled a great number of colleges and universities to develop and/or expand their teacher-training programs in mental retardation. A current analysis of the more than 300 institutions requesting funds in the area of mental retardation indicates that more than 170 of them have on their faculties former trainees who received their education under Public Law 85-926.

Under current awards policy, which gives more authority to universities to administer their own programs according to local needs and requirements it is difficult to report discrete numbers of teachers being trained for mental retardation. However it is our best judgment from review of proposals received that the number of teachers being trained for mental retardation has not diminished and funds allocated have not been reduced. Emphasis is now being placed on training teachers to serve the more severely retarded child. Institutions are changing training programs to fit this demand.

D. Cooperative Activities

The Division of Training Programs in an effort to utilize all resources in the provision of quality educational programs for all retarded children has entered into cooperative funding or working arrangements with other personnel training programs in the Office of Education and the Social and Rehabilitation Service. The following are three examples of the Division's cooperative efforts:

14 University Affiliated Facility Program

The Division of Training Programs in cooperation with the Division of Mental Retardation of the Social and Rehabilitation Service provided support monies to special education components in university affiliated facility programs for fiscal year 1972. The extent of the Division's support ranged from approximately $20,000 to $30,000 with a total expenditure of $465,000.

The Division supports a special educator on the university affiliated facility core faculty. The special educator is responsible for instructing medical students, psychologists, social workers, and other related medical personnel as well as students majoring in special education. He serves to effectively integrate special education concepts into the overall interdisciplinary training program of the university affiliated facility.

The institutions receiving support through this program for recent years were: Georgetown University; University of California at Los Angeles; Johns Hopkins University; University of Indiana; Miami University (Florida); Ohio State University; University of Cincinnati; University of Tennessee (Memphis); Children's Hospital (Harvard); University of Oregon; University of North Carolina; University of Alabama (Birmingham); Utah State University; University of Wisconsin; Georgia Retardation Center (Georgia Department of Public Health); University of Kansas; and the University of Michigan.

E. Special Projects

To provide a means for developing new models and aid developing institutes, the Division of Personnel Preparation administers a Special Projects Grant Award Program. The purpose of this program is to plan, to test new models of training, and to evaluate the effectiveness and efficiency of these new models in preparing personnel to work with handicapped children. These grants are designed to provide the wherewithal for the field of special education to develop, implement, and test new approaches for the preparation of personnel to meet current and projected needs in the education of handicapped children.

Special Project grants will be utilized to implement and test new training approaches. Successfully implemented prototype grants which provide viable approaches to training may be placed into the regular award program for future funding and disseminated to other training agencies throughout the United States for replication. During fiscal year 1973, approximately $5.0 million was awarded for almost 60 projects in colleges and universities, State and local educational agencies, and private non-profit organizations. Approximately $515,100 was expended for programs relating to mental retardation. Data on 1973 is still being compiled.

F. Future Goals

The goals of the Division of Personnel Preparation are to:

1. Increase the number and quality of personnel for education of the handicapped with special attention to early childhood education, vocational education, the urban and rural poor, para-professionals and to train regular classroom teachers to teach the handicapped.

2. Increase the amount and quality of technical assistance to agencies and institutions training professional personnel.

3. With State departments of education, effect comprehensive planning for the training of personnel in special education.

4. Develop a systematic data collection program upon which to monitor current efforts and to base future efforts.

5. Systematically evaluate current programs preparing special education personnel.

6. Effectuate qualitative evaluation of all current programs preparing personnel in mental retardation.

Educational Services

A. Purpose

The Educational Services program provides direct support to handicapped children through services at the classroom and intermediate levels. The Division offers support to State regional and local programs to assist in initiating, expanding and improving programs for the education of handicapped children.

B. Historical Development

Public Law 85-905, the Captioned Films for the Deaf Law, was passed by Congress in 1958 to provide subtitled motion picture films for the deaf. This law has subsequently been amended by P.L. 89-715 in 1965 to allow for training, research, production and distribution of educational media material for use by deaf children. In December 1967, this authority was again expanded to include educational media services to all categories of handicapped children through the 1967 amendments to the Elementary and Secondary Education Act. P.L. 91-61, passed August 20, 1969 authorized the establishment of a National Center on Educational Media and Materials for the Handicapped. The Center is developing a comprehensive program of activities to facilitate the use of new educational technology with the handicapped. The Media Services and Captioned Films program is run in conjunction with the 13 Special Education Instructional Materials Centers that were founded as a demonstration project within the Division of Research.

Public Law 89-313 was passed by Congress in November 1965, which extended the benefits of Title I of the Elementary and Secondary Education Act to handicapped children in State-operated and State-supported programs.

During recent years, as local facilities for the handicapped have increased, State schools have found the composition of their resident populations changing from the mildly handicapped to large percentages of children who are severely mentally retarded, and those who have serious handicaps in addition to mental retardation. Model and pilot programs for these types of children have been conducted under P.L. 89-313 in many States.

These funds have enabled institutions and agencies to develop programs for children who have not previously been considered capable of responding to educational or rehabilitative services. The results in many instances have been encouraging and special educators and staff in residential institutions and day classes have raised their levels of expectations for such children. While this program has had a relatively limited funding, significant results have been realized, especially in terms of planning for comprehensive services. Monies allotted under P.L. 89-313 for handicapped children were $15.9 million for fiscal year 1966, $15.1 for fiscal year 1967, $24.7 for fiscal year 1968, $29.7 for fiscal year 1969, $37.5 for fiscal year 1970, $46.1 for fiscal year 1971 and for fiscal year 1972, $56. In fiscal year 1969, 63,605 mentally retarded children were assisted under this program at an expenditure of $14, 379,663; in fiscal year 1973, over 98,000 mentally retarded children have benefitted under this program at an expenditure of $47,850,000.

During 1970, Public Law 91-230 incorporated the former Title VI-A of the Elementary and Secondary Education Act, into Part B of the Education of the Handicapped Act. This program is a State plan program which provides support to local education agencies through their State Departments of Education. About $15 million are expended under Part B for mentally retarded children. More than 151,000 mentally retarded children are served in Part B projects.

16 Of the approximately 75 million children in this country, more than seven million, including about one million preschoolers, are handicapped. This means that more than one child in ten is either mentally retarded, hard of hearing or deaf, visually impaired or blind, emotionally disturbed, crippled or in some way health impaired. At present, it is estimated that less than 60 percent of these children are in educational programs designed to provide for their unique learning characteristics.

The Regional Resource Centers were established under Part C of EHA and have as their goal encouraging and promoting the development and application of appraisal and educational programming practices for handicapped children. The centers have used demonstration, dissemination, training, financial assistance, staff expertise, and services as strategies for carrying out the mission. The centers also act as a backup agent where State and local services are non-existent or inadequate.

In 1974, $7,243,000 was spent for these activities. Nearly 40,000 children received services from the six Regional Resource Centers that functioned in 1974. Approximately 15,000 of these children were mentally retarded. In addition, support was provided to 200 State educational agencies and 6,000 local education agencies in bringing services to the Nation's handicapped children.

As part of a comprehensive effort to demonstrate innovative approaches to solve the needs of handicapped children, Title III of the Elementary and Secondary Education Act as amended in 1966, mandated that 15 percent of its project funds be set aside for special education programs for the handicapped.

Title III projects should not be designed "to meet the needs of handicapped children" but rather to demonstrate the solutions to critical problems in American education as they relate to the handicapped. It is recognized that the needs of these children will be met when appropriate programs are designed and implemented but this should not be the major thrust of Title III funds for the handicapped.

In many respects the intent of the legislation has been met. In other respects it has not. As more sophisticated procedures for identifying handicapped children are developed, as projects to serve these children are conceived, as the innovativeness and creativity of the project designs are improved, Title III personnel, working jointly with special education personnel and other local, State and Federal agencies will be in a better position to meet the mandate of the legislation.

In fiscal year 1975 Federal support for Title III will be included in a new consolidated education grant legislative program.

Under the Vocational Education Amendments of 1968 which were funded in fiscal year 1970, a number of programs were developed by vocational education agencies in fiscal year 1970, a number of programs were developed by vocational education agencies in which 115,300 handicapped persons were enrolled. Vocational Education reports do not give data by category of handicapping conditions but a review of reports indicates that the majority of enrollment increased to 208,781 with the same emphasis being given to the Educable Mentally Retarded. In fiscal year 1972 enrollment rose to 221,342 and it is evident that a wider segment of the handicapped are being served. Deaf, Blind, Crippled, Emotionally Disturbed, and Mentally Retarded Educable and Trainable were all listed among the categories being served. Unvalidated information indicates that the largest single category is still the Mentally Retarded with more than half of the enrollments being so diagnosed.

Mentally retarded are being served in special classes in State schools, in local educational agencies, and in regular vocational education programs in vocational schools. In most programs the objective is to provide those services and program modifications which will assist the mentally retarded person to become employable at the highest level of which he/she is capable. We are finding that we have underestimated the potential of many and are modifying our approaches to provide more individually prescribed instruction and better assessment of potential through use of Vocational Rehabilitation/Vocational Assessment programs and through other assessment tools.

Inservice training of vocational education instructors to enable them to better serve the handicapped has been supported at the National level and is being offered in all States under State Department of Education, Vocational Education Division. Teacher Training Institutions for Vocational Education Leadership are becoming increasingly active in providing preservice and postgraduate education for vocational education instructors concerned with handicapped students.

In most local programs, any mentally retarded adults that are served are included in the regular groups. As the Adult Education Program is expanded to serve more adequately groups with special needs, mentally retarded adults will be provided specialized programs, with increased cooperation between the Adult Education Program and local programs and services designed to serve the mentally retarded.

	FY 1973	FY 1974	FY 1975
Special Projects	$134,676	$200,000	---

An Adult Education special project funded in fiscal year 1971 and extending into 1972 received another grant in fiscal year 1973 for dissemination of materials and for other activities leading to diffusion and adoption of products of the project. The Missouri Division of Mental Health, in addition to the curricular packages and criterion referenced tests being disseminated, will provide inservice training and development services, primarily through two workshops for replicating the project in other institutions operated by the Missouri Division of Mental Health, and selected State and National ABE agencies. An Advisory Council is providing assistance through coordinating activities and through helping with the preparation of materials.

It is anticipated that in fiscal year 1974 another project to develop a career education model for mentally retarded adults will be funded in response to the increasing recognition in State grant programs of the need to serve this special adult population.

P.L. 91-230 (formerly P.L. 90-247) provides for the development of regional centers and services for deaf-blind children under Part C, Title VI "Education of the Handicapped Act." The appropriation for 1970 was $2 million and was used to continue support of eight regional centers to provide direct services for deaf-blind children in their region. The law permits use of the funds for deaf-blind children with additional handicaps, including those who are mentally retarded. The appropriation in fiscal year 1971 was $2.5 million, in fiscal year 1972, $5 million, in fiscal year 1973, $15.8 million, and in fiscal year 1974, $14.1 million.

The Handicapped Children's Early Education Program (P.L. 91-230, Part C, formerly P.L. 90-538) supports the establishment and operation of model preschool and early education projects designed to demonstrate a variety of effective approaches in assisting handicapped children during their early years. These projects will be distributed strategically throughout the country and the long-range objective is to provide visible, accessible models so that public schools and other agencies may replicate their programs. For fiscal year 1970, $3 million was granted to 41 projects. (23 operational projects were funded at approximately the $100,000 level; 4 combined planning-operational projects at about the $40,000-$60,000 level; and 14 planning projects at about $25,000 each). In fiscal year 1971, $7,000,000 supported 41 operational and 28 planning projects for a total of 69 projects. In fiscal year 1972, $7,500,000 supported 62 operational and 28 planning projects for a total of 90 projects. In fiscal year 1973, $12,000,000 supported 85 operational and 33 outreach projects; and in fiscal year 1974, $16,219,000 supported 95 operational and 45 outreach projects.

18 C. Impact on Mental Retardation

Programs will have a significant and far-reaching impact upon education and rehabilitation of mentally retarded individuals. Through such direct support programs Title VI (aid to local programs), P.L. 89-313 (aid to State programs), more extensive and comprehensive programs will develop which will include the utilization of the latest teaching techniques and educational technology. Media Services and Captioned Films for the Deaf with expanded responsibility should provide for an opportunity for State and local programs to take advantage of educational materials, media, and equipment especially designed to meet the needs of the handicapped. Certainly the newly established interest in early education programs for the handicapped will have major impact on mental retardation. This is especially so in the case of those youngsters from culturally disadvantaged areas who greatly need early stimulation. Without such stimulation, it is highly probable that many of those youngsters might become special education candidates.

D. Current Activities

Under the State plan programs, forty percent of the 115,035 children served by this program during fiscal year 1969 are mentally retarded. It is estimated that a similar number of children received direct services during fiscal year 1970. Approximately 37 percent of the $24.5 million expended in projects during fiscal year 1969, was spent for special educational and related services for the mentally retarded.

These programs have led to an interest in comprehensive planning. The Division plans to work with State and project personnel to develop long-range plans and evaluation procedures during 1970. These activities are serving the special educational and related needs of retarded children through such programs as preschool, elementary, and secondary education projects which may include: curriculum enrichment, expansion, improvement; summer school programs; preschool and school readiness programs; physical education and recreation; prevocational and vocational training; inservice training of teachers; and improved diagnostic services.

E. Future Goals

The goals of the Division of Educational Services are to:

1. Provide significant support monies to both State-supported and local educational programs to assure quality education for all handicapped children.

2. Provide intermediate services such as comprehensive educational diagnostic resource centers on a regional base to provide services for handicapped children and their families. In addition to direct services to children these centers will provide consultative services to State and local educational agencies to assure the latest available information from research with respect to the learning process.

3. Provide wherever needed comprehensive regional programs for severely multiply handicapped children such as deaf-blind children.

4. Provide through media services the research, production, and distribution of specially designed materials and programs for educational technology for handicapped children. To provide training in the use of media for teachers of the handicapped.

5. Provide through Instructional Material Centers and Regional Media Centers educational management and information systems.

Research

A. Purpose

The Division of Research promotes and supports research and related activities which show promise of leading to improvement in educational programs for handicapped children. Support is available for research, dissemination, demonstration, curriculum, and media activities, and for support of Regional Resource Centers.

B. History

The program now administered by the Division of Research was initiated during fiscal year 1964 with an appropriation of $1 million authorized under Title III, Section 302 of Public Law 88-164. The scope and flexibility of the program have been extended through amendments to this basic authorizing legislation in Public Law 89-105, Public Law 90-170, Public Law 90-247 and Public Law 91-230. Table II provides data on the authorizations, appropriations, obligations, and number of projects supported under this program.

Table II - Division of Research -- Historical Data

Year	Authorization	Appropriation	Actual Obligations	Number of Projects
1964	$ 2,000,000	$ 1,000,000	$ 999,739	34
1965	2,000,000	2,000,000	2,000,000	53
1966	6,000,000	6,000,000	5,994,231	133
1967	9,000,000	8,100,000	8,049,041	127
1968	19,500,000	11,100,000	10,794,113	135
1969	21,750,000	13,600,000	13,593,786	160
1970	28,000,000	19,700,000	15,157,670	135
1971	29,500,000	18,850,000	18,815,124	93
1972	45,000,000	14,805,000	14,413,262	86
1973	45,000,000	9,916,000	9,834,109	89
1974	10,000,000	9,916,000	9,916,000	100

C. Impact on the Problem of Mental Retadation

It is difficult to assess the direct impact of research activities since the lag between the discovery of new knowledge and consequent changes in educational practices obscures the picture. However, some information on the impact of the program is available. As of the end of fiscal year 1971, approximately 350 reports of research monitored by the Division of Research had been made available to practitioners in the field. Many of these research projects have also resulted in other publications in the professional literature. Although the systematic collection of data on the actual implementation of research findings from these projects is just beginning, there are many instances in which these findings have had a direct impact on programs for the mentally retarded.

D. Current Activities

The Division currently supports a variety of research and related activities relating to the education of mentally retarded children. A major applied research program is involved in a number of studies on the effects of teacher behavior on pupils, and on ways of establishing desired teacher behaviors. Another major program is investigating methods of optimally matching learning characteristics of retarded children with various teaching methods and environments. A comprehensive program of curriculum development activities is currently being supported by the Division. The correlated program includes projects on reading, mathematics, social studies, physical education, academic readiness, and science, each designed to produce both curricula and teaching materials for educable mentally retarded children. An additional project is developing social living and prevocational training materials designed for trainable children.

Additional efforts of a more general nature have important implications for retarded as well as other handicapped children. One of the most critical projects currently being supported is investigating the reintegration of handicapped into regular education programs. A series of 11 demonstration projects are currently involved with study and development of techniques for integrating the wide variety of community services available to retarded and other handicapped children.

E. Future Goals

The history of research on handicapped children suggests that minimal gains are obtained by spreading research monies too thinly. Many of the most important problems in education require a massive effort if solutions are to be found in time to help today's children. The Division of Research now supports five Research and Development Centers to focus on the more difficult problems of evaluation, communication, instructional procedures, etc. of handicapped children. Through the combined efforts of Research and Development Centers and programmatic research, definite improvement in instructional procedures may well be realized within the next several years.

At the same time, systems of dissemination are being evolved which will facilitate the acceptance of these new models by local school administrators. The new systems of dissemination are being built upon the foundation already developed by the Instructional Materials Centers and a system of Regional Resource Centers currently being developed.

Programs funded by Title I, Library Services, of the Library Services and Construction Act (LSCA) benefit many mentally retarded children and adults whether they live in State or local residential facilities or in private homes. Under this State administered matching program, libraries are established and improved in residential institutions operated or substantially supported by the State; specialized materials and services are provided to persons who, because of a physical handicap, are unable to read or use conventional printed material; and public library services are extended and improved in areas where they are inadequate.

It is difficult to estimate the number of public library programs reaching the mentally retarded because they are often part of broader services such as Library Outreach, Summer Reading Programs for Children, etc. There is growing evidence, however, that public libraries are developing collections and programs for mentally retarded persons who visit the library individually or in groups, and are taking services to those who do not come to the Library.

In 1973, sixty of the approximately 150 eligible State institutions for the mentally retarded received special LSCA, Title I grants for the improvement of library services to residents. In addition, all the eligible institutions benefited indirectly, at least, by the provision of services by State and public libraries through such activities as interlibrary loan, film circuits, talking books and training and consultative services.

Two outstanding examples of special LSCA projects for the mentally retarded are:

Mississippi - The State Library Commission uses LSCA funds to help fulfill its responsibility for library services in State institutions. Since 1968, library resources of the Ellisville State School have been improved by the provision of professional staff members and the expansion of the collection of multi-media materials. In 1972, the School established a central library for the first time, making possible a centralized resource center and space for group programs in the library. The librarians continue to deposit suitable book collections in the dormitories, and conduct story hours, film-strip, music and other experimental programs throughout the institution.

Washington - Since April 1971, the King County Library System with headquarters in Seattle, Washington has been developing a project, "Library Service to the Non-Institutionalized Mentally Handicapped" with support from five sources including LSCA. In attempting to reach the estimated 34,000 mentally retarded in the county, the library works with preschools, special education classes, group homes and sheltered workshops supplying materials, story hours and films out in the community as well as serving individuals and groups in various libraries in the System. The service has been eagerly accepted as a valuable source of educational and recreational activities by families, teachers and others working with the mentally retarded.

Title II of the Elementary and Secondary Education Act provides school library resources, textbooks, and other instructional materials for the use of children and teachers in public and private elementary and secondary schools. Participation is open to children and teachers in State-supported or private institutions for the mentally retarded, or other mentally exceptional children. Reports from school districts indicate a high degree of attention to the needs of retarded children.

Examples of projects which indicate how ESEA, Title II has contributed to these specialized needs are:

Breakthrough of Overcoming Learning Difficulties (BOLD) - The focus of this project was to encourage Montgomery, Alabama pupils with learning disabilities to reach their potential in reading and other areas of achievement. The Title II contribution was $15,000.

Special Education Reading Project - In this project, $1,000 was used to provide suitable media for children enrolled in the Sharpe Health School, Washington, D.C. who, because of severe and specific learning disorders, perceptual-motor deficiencies, sight and hearing loss, and language and adjustment problems, need intensive remediation.

PUBLIC HEALTH SERVICE

Health Services Administration
Bureau of Community Health Services

Maternal and Child Health

Maternal and Child Health service programs designed to meet the needs of children with mental retardation or developmental delay have demonstrated continued growth in three major areas: 1. Basic health and supportive services; 2. Preventive services; and 3. Training of personnel to deliver these services.

Through programs supported with previously earmarked portions of MCH and CC funds, States are demonstrating both the unique and specific contributions which can be made on a State and local level in evolving balanced services for retarded children and those handicapped children who show a developmental lag.

Through the mechanism of basic formula and special project grants, new and better ways of meeting need and delivering care have been demonstrated. Because of the demonstration nature of the programs, they do not provide total services for an area or community.

I. Basic Health and Supportive Services

Maternal and Child Health Services

Section 501, Title V, Social Security Act, authorizes annual formula grants to the States to extend and improve health services for mothers and children, especially in rural areas.

These are basically programs to improve nutrition, prevent ill health and infectious disease, safeguard the period around pregnancy, and minimize health hazards by identifying them as early as possible. State maternal and child health programs included some of the following services for fiscal year 1972:

. Maternity nursing services to 624,200 mothers.

. Family planning services to 1,052,663 women.

. Prenatal and postpartum care in maternity clinics for 335,200 mothers.

. Nursing services to 2,792,805 children.

. Dental treatment for 807,527 children.

. Vision screening for 8,821,010 children.

. Audiometric testing for 6,006,355 children.

. Well child conferences, serving 1,539,376 children.

Crippled Children's Services

Section 501, Title V, Social Security Act, authorizes annual formula grants to the States to find children who are crippled or who are suffering from conditions leading to crippling, and to provide them with medical, surgical, corrective and other services.

A total of 512,881 children received physician's services and 80,932 received hospital inpatient services under State crippled children's programs in 1972.

More children in every age group, from infant through adolescent, received services in 1972.

Congenital malformations accounted for 21 percent of all conditions noted, and more than 19 percent of the children served were reported to have multiple conditions, including mental retardation.

Clinical Services

Clinical services for mentally retarded children operating in all but two States include diagnosis, evaluation of a child's capacity for growth, the development of a treatment and management plan, interpretation of findings and counseling of parents, and follow-up care. Mental retardation clinic services were provided for over 75,618 children, and 363,107 visits made to 166 clinics supported by MCH funds during FY 1973.

Children are being seen at these special clinics at an earlier age as a result of multiple screening procedures carried out by the State maternal and child health programs. 40.2 percent of the new patients seen in these clinical programs were under 5 years of age; 39.8 percent were 5-9 years old; 15.4 percent were aged 10-14.

New patients numbered 31,891. These clinical programs fulfill a major function of "unlabeling" children referred as mentally retarded. Among children classified in FY 1973, 10,786 were found not to be retarded.

Multiply-Handicapped Children's Clinics

Ten specialized clinical programs for multiply-handicapped children are providing comprehensive services for children with a multiplicity of handicapping conditions including mental retardation. They continue to serve as models for the type of staffing and services required to meet the total needs of children in a single setting.

Genetics Program

Twenty Projects supported with CC funds provided cytogenetic and biochemical laboratory services as extensions of clinical services at selected medical centers. Newer and more efficient laboratory techniques adapted for service delivery from research programs are being demonstrated in the provision of genetic counseling to families served in these centers.

II. Preventive Services

Maternity and Infant Care Projects

Section 508, Title V, Social Security Act, authorizes grants for projects to help reduce the incidence of mental retardation and other handicapping conditions caused by complications associated with childbearing and to help reduce infant and maternal mortality by providing necessary health care to high-risk mothers and their infants.

Fifty-six Maternity and Infant Care projects, located in 34 States, the District of Columbia and Puerto Rico were operational in fiscal year 1973. While more than 60 percent of the Maternity and Infant Care projects serve cities of 100,000 or more, projects are also located in rural and urban-rural populations in such States as Alabama, Georgia, Florida, Arkansas, Idaho and others. All the projects serve localities which have shown higher infant and maternal mortality rates than the Nation as a whole.

Approximately 1,030,271 women have been submitted for maternity care and 714,866 for family planning services since the Maternity and Infant Care program was established.

Inborn Errors of Metabolism

Phenylketonuria (PKU), an inborn error of metabolism, has in the past been responsible for 1 percent of the population in the State institutions for the mentally retarded. By detecting families with the condition and by providing young infants with the condition with a special diet, mental retardation usually can be prevented. BCHS works with State health departments in developing the necessary laboratory facilities and assisting States to provide special diets and follow-up services for these families.

Approximately 90 percent of the newborns in the 50 States and the District of Columbia were screened. This effort by the States turned up approximately one confirmed case for every 16,000 live registered births.

BCHS is continuing to support a study of the clinical application of screening tests to detect galactosemia, maple syrup urine disease and histidinemia. Support is also being given to studies of new approaches to broader screening methods which would make available a battery of automated tests for detecting metabolic diseases. In the meantime the PKU collaborative project involving 16 treatment centers throughout the country is attempting to determine when and how children with PKU, who have been on treatment since birth, can be discontinued on the special diet without harmful effects.

Lead Poisoning

BCHS Children and Youth projects are continuing to screen their populations for lead poisoning as a part of their health maintenance program. Earlier detection and treatment is being achieved. Of 49 projects that responded to a survey on the problem of lead poisoning, 51% stated that this continued to be a major public health problem among their patients. Two projects were routinely testing all of the children seen by them, 12 projects were testing all children under 6 years of age, and 20 tested children considered high risk for lead poisoning. 18 of the projects reported a total of 922 children treated for lead poisoning for the twelve month period ending September 30, 1972. At the same time, screening programs are finding some children with elevated blood levels who do not live in dilapidated housing and do not have a history of pica.

Rh Factor

State maternal and child health programs reported continued progress during fiscal year 1973 in the prevention of hemolytic disease of the fetus and newborn through the use of anti-Rh immune globulin. An increasing number of States are utilizing MCH formula funds to provide immune globulin to women needing it.

With the liberalization of abortion laws, it will become critically important that the utilization of anti-Rh immune globulin also be made available to these patients.

Rubella

Many of the babies born with birth defects resulting from the rubella outbreak of 1964 and 1965 and showing evidence of mental retardation or other handicaps continue to be cared for under special clinical programs for retarded handicapped children. The President's Committee on Mental Retardation estimates that the nation is now paying $140 million for the care and treatment of these child victims. Outbreak of rubella in isolated communities were reported during 1973 and States are encouraged to use MCH funds to complete the immunization of children against rubella as part of the national campaign spearheaded by the Center for Disease Control.

III. Training

Under Section 511, Title V, Social Security Act, grants are made for the training of personnel in health care and related services for mothers and children, particularly mentally retarded children and children with multiple handicaps.

Training activities are also supported by funds authorized under Sections 503 and 504 of Title V for projects which may contribute to the advancement of maternal and child health and crippled children's services.

University-Affiliated Centers

The program designed to provide comprehensive multidisciplinary training of specialists who will work with the handicapped and retarded is based on a concept of multi-agency funding and multi-departmental university participation. It had its beginning in 1963 under P.L. 88-164, which authorized Federal support in the construction of facilities to house such training efforts. At many of the universities that applied, MCH was already involved in the funding of clinical services.

The University Affiliated Centers have developed effective programs of prevention, treatment, and rehabilitation. Each offers a complete range of clinical services through a core faculty representing at least 20 professional disciplines, who work together to demonstrate a continuum of services for the handicapped and to train a variety of students. While all basic objectives are similar, each center is shaped by its staff, location, physical plant, and the specific disciplines and university departments that are involved in its operations.

The Association of University Affiliated Facilities has reported that the 32 operating programs trained 50,000 students at various levels during FY 1973. This included 552 fulltime students from over 25 disciplines who spent at least 500 hours in training. Of this group MCH stipends supported 318 fulltime students in 20 of the programs represented in this association.

Indian Health Service

I. Preventive Services

A. Prevention of Organically Based Mental Retardation

The best prevention of organically-based mental retardation is an active, comprehensive, high quality program of prenatal, intrapartum and postnatal care for mothers and infants. The Indian Health Service continues to put high priority on its total services for mothers, infants and children by encouraging more and better prenatal care, better nutrition, full use of family planning services and counseling. Deliveries are provided at 47 hospitals, and outpatient pre- and postnatal care and counseling are available at all facilities.

Better nutrition of pregnant mothers, and of their infants, reduces organically-based mental retardation in infants; as does more complete prenatal care which allows earlier detection and correction of medical conditions which can harm the unborn infant.

Genetic counseling is provided when indicated, and to promote responsible parenthood family planning services are provided. These services include assistance with problems of infertility as well as with the more common problem of spacing pregnancies. Twenty-three percent of Indian women aged 15-44 were provided family planning services in FY 1973.

The Indian Health Service also continues its efforts to increase the number of infants and children immunized against measles and rubella, to reduce the number of children with brain damage and congenital anomalies that result from measles encephalitis and from maternal rubella during the first trimester of pregnancy.

The Nurse-Midwifery program continues to increase the services available for better care of mothers and children.

Services for mentally retarded patients are coordinated with state and local health departments by Area Offices and Headquarters, Indian Health Service. Assistance and cooperation of Regional Offices, through grant-in-aid funds, makes possible regional planning of programs and services for the mentally retarded.

B. Prevention of Functionally-Based Mental Retardation

As part of the ongoing comprehensive health program on Indian reservations, the Indian Health Service is working cooperatively with Headstart programs and Bureau of Indian Affairs schools and personnel in all Areas in efforts at prevention, detection, treatment and planning rehabilitation for children with functional mental retardation. The model dorm program jointly sponsored by Indian Health Service and Bureau of Indian Affairs continues as a successful mechanism in preventing functional mental retardation in early school age children.

III. Professional Preparation

A. Indian Health Training Program

The Indian Health Service continues to support physician residency training in pediatrics through Out-of-Service programs. Such training includes instruction in prevention, diagnosis, treatment and rehabilitation of mental retardation.

The Indian Health Service continues to provide both In-Service and Out-of-Service training for nursing and auxiliary personnel, including community workers (CHR's), to ensure continuity of service from hospital to homes.

The Indian Health Service continues to develop and use coordinated teaching guides for hospital and public health nursing personnel, designed as aides in teaching good health practices to maternity patients and their families.

Center for Disease Control

Rubella Immunization

Grants permitting immunization programs against rubella have been awarded to State and local health departments since 1969, when a new live rubella vaccine was licensed. These grants provide assistance in planning, developing, and conducting immunization programs to prevent and control the spread of rubella, thereby reducing the occurrence of mental retardation, blindness, and other complications associated with congenital rubella syndrome. Between July 1969 and December 1973, approximately 44 million doses of rubella vaccine were administered in the United States. Over 34 million of these were administered through public immunization programs.

As a result of the large quantities of rubella vaccine administered, reported cases of rubella have decreased from 56,552 in 1970 to 27,827 in 1973. During the first 30 weeks of FY 1974 reported cases of rubella had decreased 49 percent when compared to the first 30 weeks of FY 1972. Furthermore, the predicted 1970-1972 rubella epidemic, similar to the one in 1964 which resulted in 20,000-50,000 cases of congenital rubella syndrome, has not materialized.

Measles Immunization

Late in 1971, the Department of Health, Education, and Welfare authorized the reinitiation of project grant support for measles control programs. This action was taken when reported measles cases increased from 22,239 in 1968 to 75,290 in 1971 and has resulted in an increase in distribution and use of measles vaccine. Vaccine distribution increased from about 4 million doses in 1971 to 7.4 million in 1973. The Center for Disease Control distributed approximately half, or about 3.7 million of the total 7.4 million doses distributed, in 1973.

This increase in distribution of vaccine has been accompanied by a decrease in the number of measles cases reported (75,290 in 1971; 32,275 in 1972; and 26,686 in 1973). During the first 30 weeks in FY 1974, reported cases have declined an additional 33 percent when compared to the same period of time in FY 1973.

Although the total number of reported measles cases is declining, measles continues to pose a serious health threat. Approximately 4.7 million preschool-age children are unprotected against the disease and outbreaks of measles are now occurring in several areas of the Nation.

Prevention of Lead-Based Paint Poisoning

It is estimated that 2,500,000 children between the ages of one and six years are at risk of becoming lead poisoned because they live in dilapidated housing containing hazardous amounts of lead-based paint. Of these children who are at risk, it is believed that 600,000 have elevated blood-lead levels, and as many as 125,000 may actually be lead poisoned. Of these, 6,000 children may suffer neurological handicaps, including mental retardation. Medical investigators have determined that should a child suffer a lead encephalopathy the second time, there is nearly a 100 percent chance of permanent neurological impairment. This disease is caused principally by repeated ingestion of lead-based paint by children. Control of childhood lead poisoning is based on the identification and medical follow-up of children with elevated blood-levels and the reduction or elimination of lead-based paint hazards in their housing environments.

The Center for Disease Control will continue the national preventive program to assist communities in their efforts to determine the nature and extent of the problem, and to develop medical and scientific capabilities necessary to carry out effective local programs. These efforts are complemented by special project grants which enable communities to initiate new control programs or to expand limited existing activities. In FY 1973-1974, the first full year of operation of the national initiative to control childhood lead poisoning, approximately 300,000 children will be tested. These projects will continue to insure that a minimum of 300,000 children in identifiable target areas receive lead testing during FY 1975. In addition, beginning late in FY 1974, project grants will be used to establish State level laboratory programs.

A centralized laboratory capability in lead analysis will permit additional communities throughout the State to implement locally supported lead screening activities, and will remove a serious obstacle to the full implementation of child lead screening activities under Medicaid. In addition, these grants will be used to establish within the State Health Department laboratory a capability for providing technical assistance and performance review services to all laboratories performing lead analysis throughout the State. The long-range effect of these activities will be to greatly increase the number of children tested, and to increase the number with evidence of undue lead absorption who are identified early enough to permit disease preventing actions to be taken.

National Institutes of Health

National Institute of Child Health and Human Development

The National Institute of Child Health and Human Development (NICHD) supports research into the biological and behavioral processes which contribute to or influence the development of retarding disorders. Of primary concern are basic causes and means of preventing mental retardation. The Institute's research attack is based on research grant support, creation and support of special research facilities and resources, dissemination of scientific and public information, support of scientific conferences, and contract support of research designed to accomplish specified goals. Many of the research accomplishments supported by the NICHD have been achieved in the Institute's 12 Mental Retardation Research Centers. These interdisciplinary Centers, located throughout the country, are uniquely capable of investigating the complex problems of mental retardation, training future scientists, and applying research findings to patient services.

Lowering the number of births of Down's Syndrome babies in this country is an important project of the NICHD. Down's Syndrome, or mongolism, is a form of mental retardation known to be genetic in origin. Scientists also know that the incidence of mongolism rises with the age of the mother. Through its public education campaign, the NICHD hopes to increase understanding of older women's relatively larger risk of bearing a child with mongolism. Family planning and diagnostic procedures during pregnancy are useful for counseling purposes.

Research has defined the underlying causes of certain inborn errors of metabolism, thereby offering improved means for their treatment. There is evidence of research progress in nutrition, infectious diseases, seizure disorders, and congenital defects related to mental retardation. Similar gains are apparent in research in the behavioral, social, and communications sciences, especially those studies focused on the infant and very young child.

Basic Biological and Clinical Studies

Maple Syrup Urine Disease, which causes severe nervous system damage, is always fatal early in life if untreated. The disease has several types, differing in severity and related to the concentration of a specific enzyme controlling metabolism of certain amino acids. Early diagnosis is important to protect infants born with this disorder, since dietary treatment is possible. Diagnosis has been improved by a group of scientists at New York University supported by the NICHD. By using daily skin tests, the physicians were able to ascertain the severity of the disease and to restrict protein intake appropriately. This work also suggests means of dealing with similar genetically determined metabolic disorders.

Replacement of deficient or missing enzymes holds promise for the cure of diseases resulting from defective enzymes. Progress has been made by investigators working with one of these disorders, Lesch-Nyhan Disease, in which patients are both mentally retarded and tend to mutilate their own bodies by scratching and biting. The investigators supported by NICHD have learned that when cells from Lesch-Nyhan patients are mixed with those from normal persons, the affected cells begin to metabolize normally. This "metabolic cooperation" suggests therapy may be possible in the future.

Another route to enzyme replacement is being followed by scientists at the University of California School of Medicine at San Diego using cells from patients with Sanfilippo Disease. In this disorder a specific substance is stored in the brain in abnormal quantities because an enzyme needed to break it down is missing. In the laboratory, when the purified enzyme was added to the enzyme-deficient cells from Sanfilippo patients, cell growth was normal. When the enzyme was not present, however, build-up occurred in the cells. This lead was followed by other investigators who have tested the effects of the purified enzyme in Sanfilippo patients by administering it in normal blood plasma. This approach, which is still being pursued, has not yet been successful, possibly because too small a dosage of the enzyme was given.

Dietary Aspects of Mental Retardation

Scientists at the Mental Retardation Research Center in Wisconsin are working to detect healthy carriers of phenylketonuria (PKU) whose children could inherit the disease. Advance knowledge that a pregnant woman is a carrier helps the physician to begin a dietary regimen which can prevent mental retardation in the child. Recent experiments showed that the investigators' tests can be used to screen women who had been taking oral contraceptives (OCs). This is important, since women using OCs often react differently to metabolic tests than other women. Experiments also revealed that test results can be influenced by obesity of the women, indicating that the tests must be further refined and their validity in obese women examined.

In offspring of pregnant rats, malformation of the brain produced by dietary zinc deficiencies provide a model that shows even short-term dietary deficiencies can affect the developing brain. These studies, conducted at the Institute for Development Research of the Children's Hospital Medical Center in Cincinnati, do not prove that zinc deficiencies affect human fetuses, but do lay the groundwork for further important nutritional research.

Tay-Sachs Disease is a genetically-transmitted fatal disorder. Widespread efforts are now being made to identify couples at risk of producing affected offspring. Such screening is possible because carriers of the disorder have a higher concentration of a certain enzyme in their blood than non-carriers. Researchers at Albert Einstein College of Medicine found a variant form of a certain enzyme, hexosaminidase, in serum and cell extracts from patients with Tay-Sachs Disease. Carriers who do not exhibit the disorder themselves, but who can pass it on to offspring also have this variant enzyme, although in lesser quantity.

Behavioral Studies

Investigators at the Children's Hospital Medical Center in Boston observed minor neurophysiological handicaps in delinquent boys and found the abnormalities similar to those in boys with mild learning problems. This may indicate that one of the reasons for delinquency is nervous system impairment and learning disability.

Investigators at the University of Washington Mental Retardation Research Center have evidence that early educational intervention may improve the development of the retarded child. They showed that preschool classroom training and parental instruction can result in significant gains in cognitive, speech and language, motor and self-help performance in Down's Syndrome children in age groups from birth to 18 months, 19-36 months, and 3-5 years.

[34] Behavioral studies have shown that normal infants learn more rapidly when clear connections ("contingencies") are made between their behavior and changes in their environment. For example, when a child's sucking response is rewarded by milk only in the presence of an overhead light, he or she will learn to respond (suck) when the light is on. Very young infants are capable of only a limited number of responses; that is, they can blink, and suck, but cannot speak or grasp. This probably is even more true of damaged or high-risk infants. Studies supported by the NICHD indicate that providing infants, especially those who are damaged or at high-risk, with artificial contingency experiences very early in life may improve their intellectual development.

Support of this view is provided by studies of premature infants at Brown University laboratories. Investigators showed that premature infants given handling that provided them with artificial contingencies during their extended hospitalization did significantly better on a visual conditioning task than the infants who had not been so handled. The performance of infants given the special handling was similar to that of full-term one-month infants. The apparent deficits in learning of the unhandled infants pose important questions about whether lack of appropriate stimulation may affect babies' visual exploratory behavior.

National Institute of Neurological Diseases and Stroke

Neurological disorders caused by biological factors account for a large percentage of the mentally retarded. The biological factors include any which cause physical or chemical damage to the brain or nervous system--a virus, a poison, an accident, or a hereditary factor such as an error in metabolism or a missing gene. Scientists also are seeking any unknown causes of damage to the brain before, at, or around the time of birth. The National Institute of Neurological Diseases and Stroke (NINDS) studies the biological factors known or suspected to be related to mental retardation.

The NINDS supports a large number of research projects aimed at clarifying metabolic derangements leading to central nervous system damage and at identifying specific injuries to the brain or other parts of the nervous system. The programs deal specifically with neurological disorders of early childhood including cerebral palsy, birth injuries (both discussed in a separate report), Tay-Sachs and other lipid storage diseases, kernicterus, phenylketonuria, mongolism, spina bifida, and hydrocephalus. These disorders are often accompanied by mental retardation

Researchers sponsored by NINDS also seek answers to fundamental biological, biochemical, or molecular processes critical for complete understanding of mental retardation. Such studies are of more long-term importance for real solutions (prevention, cure, or treatment) of disease than simple alleviation of symptoms.

Collaborative Studies Related to Children

One of the Institute's most significant research projects relating to mental retardation is the collaborative study of the development of children. The NINDS worked with 14 cooperating institutions to conduct the Collaborative Perinatal Research Project. This Study made and recorded observations of some 58,000 women and their pregnancies to investigate the prenatal, perinatal, and postnatal factors of child development. Most of the surviving children have been given a series of tests through age eight.

As a result of the Study, scientists have learned such things as the distribution of blood antibody levels, the consequences of high bilirubin levels in nursery age children (which produce jaundice and can cause brain damage), the distribution of physical and intellectual measurements, and the frequency of certain abnormal conditions. Researchers have found low birth weight to be a very important factor in stillbirths, in neurologic abnormalities, and slow intellectual development.

Since the Study began in 1959, over 500 scholarly papers have been written on the findings. As analysis and interpretation of data are completed, monograph reports will be published in book form on cerebral palsy, mental retardation, communicative disorders, minimal brain dysfunction, congenital malformations, birth weight gestational age relationships (prematurity), and neuropathology, general pathology, and placentology.

Research Grant and Training Program

The NINDS supports research on the developing nervous system and its disorders which has the potential for yielding important information relating to the problem of mental retardation, the most devastating consequence of these disorders. Through its research training grant programs, the NINDS has stimulated a number of individuals to enter research careers in the fields of child neurology, speech pathology, and audiology. These specialists are now in the forefront of those seeking new information on the early diagnosis and treatment of mental retardation and the accompanying impairments, especially problems of communications.

Genetic Disorders Related to Retardation

There are over a thousand genetic disorders that afflict man, and among them are the inborn errors of metabolism, which are of special interest to NINDS researchers. Many of these cause severe mental retardation or early death. Of the 200 known, 40 can now be detected before birth by tests of the amniotic fluid obtained by amniocentesis from the pregnant mother.

Although only a few of these disorders are treatable, many of them can be prevented through genetic counseling. Standardization and wider use of amniotic fluid tests during the past year have improved prenatal diagnosis and carrier detection, and have also led to improved diagnosis of the nine known lipid storage diseases. These disorders often cause severe mental retardation. Pioneering biochemical research on metabolic pathways by NINDS-supported scientists has made it possible to pinpoint the specific enzyme defect in all nine lipid storage diseases, including Tay-Sachs Disease. Such studies have already provided clues to possible treatment for some of the disorders while other research is aimed at improving prenatal diagnosis and carrier detection tests. Such improvements combined with genetic counseling could lead toward eradication of these inborn errors of metabolism.

Retardation Caused by Hydrocephalus

Mental retardation often follows hydrocephalus (an increase in the size of the normally fluid-filled cavities and cisterns within the brain causing brain damage) and brain tumors in childhood. Scientists are working to develop appropriate surgery and drug treatment and are using antitumor materials tagged with radioisotopes to improve chemotherapy. Tests were conducted last year and will continue this year on the use of a tomoscanner and will be supplemented by use of the newly ordered EMI-scanner to aid scientists in detection of brain tumors.

In Fiscal 1973, the NINDS supported 148 studies on neurological disorders of early life, a large number of which are accompanied by mental retardation, at a cost of $7.9 million. Intramural and collaborative programs, including the Perinatal Project, numbered 101, at a total cost of $7 million.

Alcohol, Drug Abuse, and Mental Health Administration

Research on mental retardation has been supported by the National Institute of Mental Health for over a quarter century. Although major responsibility for the mentally retarded was shifted to another Federal agency a few years ago, the Institute's program continues to be concerned with the retarded. Some research projects deal directly with mental retardation; many of these projects were started several years ago. Others have indirect or potential significance for retardation.

Several studies are related to the prevention of mental retardation, especially environmentally induced mental retardation. One extramural project, in which Institute staff members also have been involved, set up and evaluated a home-tutoring program for culturally deprived infants. A similar effort to prevent cognitive defects is being carried out in the homes of disadvantaged children before they reach the age of 3. These investigators are attempting to alter the mother's teaching style, language style, and management procedures when necessary.

Using a school-based model for preventing mental disorders, other researchers are testing the ability of teachers to promote self-awareness and interpersonal functioning among their pupils, while at the same time decreasing pathological manifestations. The project is nearing completion. An experimental Office of Child Development program for educating adolescents about parenthood had its origins in a study supported by NIMH.

Detection and classification of retardation are the concern of other NIMH-supported researchers and staff members. One investigator is assessing the capabilities of low-IQ children in order to better differentiate among them. Besides measuring learning potential among the educable mentally retarded, he will develop another measure of learning potential for use with primary grade children; then he will initiate a longitudinal study of young nonlearners--their trainability in memory, learning, and speech functioning. NIMH staff members, meanwhile, are developing a preschool test using prepositions as an instrument for screening children between ages 3 and 5 for mental retardation. Still being researched, the test has been used with promising results in Head Start classes and on disadvantaged populations. At present, it is being used on about 700 Maine youngsters to detect developmental lag.

In another project, the investigator is developing methods for differential diagnosis of reading disability, on the assumption that not all "retarded" readers are in the same category. This project is the outgrowth of earlier work on bisensory memory and audiovisual matching.

A behavior evaluation program, now in its 7th year of support, is an effort to develop and test an objective laboratory procedure to supplement clinical techniques for describing, predicting, and modifying behavior of mentally retarded children.

Three separate, but related, studies on the social and behavioral aspects of mental retardation in school children were done by a California investigator. This research, which has produced over 200 articles, chapters, and volumes that have been widely disseminated has been supported by NIMH for 7 years. It has resulted in a model for reporting biannual evaluation of hospital patients and changes in their social and behavioral characteristics. Another long-term investigation has explored the learning and transfer processes in retarded children.

Longitudinal investigations of the epidemiology of impaired competence is being studied by another NIMH investigator, while still another is trying to determine the epidemiology of exceptionality in school children. The latter considers children "exceptional" if they are educationally handicapped, gifted, mentally retarded, emotionally disturbed, or physically handicapped. She plans to relate clinical characteristics, such as IQ, adaptive role behavior, and physical disabilities, to modes of sociocultural characteristics for black, English-speaking Anglo, and Mexican American children.

Over the past years it often has been pointed out that classifying children, especially exceptional children, according to diagnostic categories may have deleterious effects. The "labels" or names may have unfavorable connotations and imply predictions of future behavior. Such labeling might be particularly important in some kinds of recordkeeping, as, for example, cumulative records in a school system. The NIMH has sponsored a significant study of this problem, and a book "The Futures of Children: Categories, Labels, and Their Consequences" has been published.

Biological studies are also underway that are directly or potentially relevant to mental retardation. For example, one researcher is studying the relationship between abnormal metabolism and mental disease including, among other subjects, infants with phenylketonuria (PKU) and mentally retarded individuals; emphasis is on identification of abnormal chemical reactions in mentally ill and retarded individuals, especially the metabolism of aromatic acids in tissues and urine. Another study is investigating the psychophysiology of sleep and dreaming in mentally handicapped, as well as other, individuals. Another basic research project is concerned with the structure, distribution, and metabolism of acid mucopolysaccarides in nervous tissue; this work should lead to a better understanding of the origins of central nervous system abnormalities, such as mental retardation.

The Institute's research program, then, covers a wide area of investigations with important relevance for mental retardation. Especially in basic research efforts, ranging from studies of the effects of environment on behavior to analysis of nervous system tissue, knowledge is accumulating that will result in a more thorough understanding of the phenomena of mental retardation, and of ways to prevent it.

Health Resources Administration

Bureau of Health Resources and Development
Health Care Facilities Service
(Hill-Burton Program)

Mental retardation facilities have been eligible for and have received construction assistance from the Hill-Burton program since its inception twenty-six years ago. Up until the passage of the "Mental Retardation Facilities Construction Act" (1963) - P.L. 88-164, Title 1, the Hill-Burton program was the primary source of federal assistance for retardation construction, and administered the Act after enactment until August 1967. Since the advent of the specific construction programs for retardation facilities, the Hill-Burton program has been acting primarily as a backup resource for construction aid. As of June 30, 1973, a total of 108 retardation projects have been assisted with $56.6 million in federal funds since the Hill-Burton program began. Hill-Burton personnel in both the regional H.E.W. offices and in the State Hill-Burton agencies have provided expert consultation to the retardation facility programs and to many retardation project sponsors or potential sponsors. Hill-Burton consultation is especially valuable where retardation services are to be provided in a comprehensive health care facility or in any combination with other health services.

SOCIAL AND REHABILITATION SERVICE

Mental Retardation

Introduction

On August 15, 1967, the Social and Rehabilitation Service was established by the Secretary, Department of Health, Education, and Welfare, to join under a single leadership income support programs for needy Americans and the social and rehabilitation programs, including services for the mentally retarded.

Five of the eight major components of the Social and Rehabilitation Service have responsibility for providing income maintenance, medical services, social services, and rehabilitation services for the economically, physically, and mentally handicapped. These bureaus and offices administer the legislation concerned with the care and provision of services for retardates and their families in the following order: Assistance Payments Administration - Social Security Act, Title IV, Part A. Medical Services Administration - Social Security Act, Title XIX. Community Services Administration - Social Security Act, Title IV, Parts A and B, and Title VI. Office of Planning, Research, and Training - Social Security Act, Title XI, Sections 1110 and 1115, and the Rehabilitation Act of 1973. Rehabilitation Services Administration - the Rehabilitation Act of 1973, the Developmental Disabilities Services and Facilities Construction Act, and various other Acts or portions of Acts such as the Public Health Service Act, concerned with the health and welfare of the mentally ill or retarded. Following is a description of the Social and Rehabilitation Service's efforts on behalf of the mentally retarded.

Assistance Payments Administration

The Assistance Payments Administration has primary responsibility for grants to States for public assistance programs under the Social Security Acts, Title IV, Part A, Aid to Families with Dependent Children and Emergency Welfare Assistance; and Title XVI, Aid to the Aged, Blind and Disabled (Guam, Puerto Rico, and Virgin Islands only). It is in the disabled portion of the latter program that Federal financial participation is available to help needy individuals who also may be mentally retarded through territorially administered public welfare program.

P.L. 92-603, enacted October 30, 1972, established a national program to provide supplemental security income to individuals who have attained age 65 or are blind or disabled except for Guam, Puerto Rico and Virgin Islands. The national program became effective as of January 1, 1974, at which time the Social Security Administration assumed responsibility for making Federal payments to eligible recipients formerly carried by the States and territories under Titles I, X, and XIV. Since the Assistance Payments Administration's authority to make payments to disabled recipients expired December 31, 1973, Federal expenditures shown in the Table of Obligations are for Guam, Puerto Rico, and the Virgin Islands only in 1975.

Mentally retarded persons eligible for money payments under the Aid to the Permanently and Totally Disabled program comprise slightly more than 28 percent of total APTD recipients. Based on this statistical calculation, it is estimated that approximately $523,000 in Federal funds will be provided for income support of the mentally retarded in the territories of Guam, Puerto Rico and the Virgin Islands.

(Dollars in Thousands)

1971	1972	1973	1974	1975
188,923	201,286	236,639	127,248[1/]	523[2/]

1/Six months for all except Guam, Puerto Rico, and Virgin Islands
2/Guam, Puerto Rico and Virgin Islands only

Community Services Administration

The Community Services Administration has responsibility for administering the Social Services Program authorized by Titles I, IV Part A, VI, X, XI, XIV, and XVI and Child Welfare Services under Title IV Part B, all of the Social Security Act.

The Social Services Program provides a wide array of services directed at assisting needy individuals to attain or maintain the highest level of independence and self-care for which they have potential. Recipients of these services are either recipients of, or potential recipients of, public assistance through either Aid to Families with Dependent Children, Aid to Aged, Blind or Disabled or recipients of Supplemental Security Income. Some of the more important services extended to the mentally retarded in these groups of people are:

(1) Day care services which facilitate the child or adult remaining in his own home in lieu of institutionalization.

(2) Short term family foster care during periods of crisis to prevent institutionalization and long term family foster care to provide benefits of family and community living in lieu of institutionalization.

(3) Services directed at attaining entrance to institutional placement where needed and services to move individuals out of institutions where feasible.

(4) Other services such as protective services, homemaker and chore services, home management, counseling, etc., which will promote retention of the mentally retarded in their own homes and assist in the development of the individual to his maximum capacity for self-care and independence. Among these are services to expectant mothers which will help reduce the incidence of mental retardation.

The basic purpose of the Child Welfare Services program is to protect children from abuse, neglect, exploitation, or delinquency and to assure that they have opportunity for normal development. Among recipients of these services are mentally retarded children from all socio-economic groups not just children who qualify for services under the IV-A Aid to Families with Dependent Children.

During fiscal year 1975 services for mentally retarded individuals will be extended to 320,000 children and adults in families with dependent children, 205,000 aged and disabled individuals under the Social Service Program, and to 36,000 children under the Child Welfare Services Program.

	(Dollars in Thousands)		
	FY 1973	FY 1974	FY 1975
Services to Mentally Retarded...........	$214,780	$233,150	$258,875

Medical Services Administration

The Medical Services Administration administers Title XIX of the Social Security Act, as amended. Title XIX, popularly called Medicaid, provides for Federal matching funds to States which have medical assistance programs for the needy. States must include in their Title XIX plans all recipients of cash assistance--AFDC families, and poor aged, blind and disabled individuals. In addition, they may provide Medicaid coverage to similar individuals who would be eligible for cash assistance, except for the level of their income and resources and who have enough money to pay for their maintenance needs but not enough to pay for needed medical care, as well as to all poor children under 21. While there is no special coverage of mentally retarded individuals as a defined group under Medicaid, mentally retarded individuals who are eligible under one of the above categories do receive Medicaid benefits.

All Medicaid services included under the State plan (mandatory services include inpatient hospital care, outpatient care, physicians' services, skilled nursing facility services for individuals 21 years of age and older, early and periodic screening, diagnosis and treatment services for children under 21, lab and X-ray services, and home health services; in addition, States may cover a range of optional services including dental care, drugs, eyeglasses, intermediate care facility services, etc.) are available to eligible mentally retarded individuals.

Effective January 1, 1972, P. L. 92-223 transferred intermediate care services to Title XIX as an optional State service and authorized the provision of intermediate care facility services in public institutions for the mentally retarded if the institution provides health or rehabilitative services and if the eligible individuals are receiving active care and treatment. To assure that the Federal dollars made available for such institutional care would lead to higher quality care and services in an improved environment, and not simply to a replacement of State dollars, the legislation contained a provision requiring the States to maintain their own fiscal effort. To date, 29 States have responded to the new Title XIX authority by adding to their State plan coverage of ICF services in public institutions for the mentally retarded. Prior to January 1, 1972, some 17 States claimed Federal matching in the costs of care in institutions which qualified as skilled nursing home services. It should be noted that because services in the past were being provided to the mentally retarded as skilled nursing home services, the adoption of the intermediate care facility program resulted in a redesignation of facilities in some States. The result is that these facilities are able to provide services at a more appropriate level of care in instances where skilled nursing care is not medically necessary. States, however, continue to provide care for the mentally retarded in skilled nursing facilities where medically appropriate.

Total Federal expenditures for services for the institutionalized mentally retarded (including ICF, skilled nursing facilities, and inpatient hospital services) were estimated to be $200 million in FY 1972. Estimates are not available on the number of Medicaid dollars expended on all other Medicaid services provided to the mentally retarded. It should be emphasized that the Medicaid eligible mentally retarded person may receive the full range of Medicaid services, and receive them on the same basis as the rest of the Medicaid eligible population.

Estimated Federal Expenditures (in Millions)

FY72	FY73	FY74	FY75
$200	$380	$420	$490

Rehabilitation Services Administration

Under the public rehabilitation program, grants are made to State vocational rehabilitation agencies to assist them in providing rehabilitation services to mentally and physically disabled individuals who have substantial employment handicaps and who can reasonably be expected to be rehabilitated into gainful employment. Among the services provided by State vocational rehabilitation agencies are comprehensive medical, psychosocial and vocational evaluation; physical restoration; counseling; personal adjustment, prevocational and vocational training; maintenance and transportation during the rehabilitation process; placement in suitable employment; services to families of handicapped people when such services contribute substantially to the rehabilitation of the handicapped client; recruitment and training services to provide new careers for handicapped people in the field of rehabilitation and other public service areas; and follow-up services to assist handicapped individuals to maintain their employment.

Recent years have seen dramatic advances in the provision of vocational rehabilitation services to the mentally retarded. The retarded now comprise about 11% of the people rehabilitated from all categories of disability by the State-Federal program of vocational rehabilitation. In 1974, about 43,000 mentally retarded persons will be rehabilitated.

Basic to the vocational rehabilitation effort has been the growing reliance on counselors and other vocational rehabilitation staff who work exclusively with retarded clients. This specialized staff may be assigned to local vocational rehabilitation offices, schools, institutions, sheltered workshops, or other facilities serving the mentally retarded. By concentrating their attention on the mentally retarded clients, these counselors are successfully developing rehabilitation plans based on the special problems of the retarded, and are able to be broadly responsive to the needs of both the client and his family. As special vocational rehabilitation programs and facilities for the retarded continue to be developed and expanded, the number of specialized counselors within State vocational rehabilitation agencies is expected to increase.

The specialized vocational rehabilitation staff working with the mentally retarded has been particularly effective in the development of cooperative vocational rehabilitation-school programs designed to assist the retarded young person make a satisfying transition from school to work. These cooperative programs are found in many communities throughout the country and have greatly strengthened both special education and vocational rehabilitation efforts with the mentally retarded. The cooperative program structure varies from State to State, and the variety of approaches is extraordinary. In some States, program administration is Statewide and in others there are separate agreements with individual school districts. Some programs function only to serve the mentally retarded, while others include youth with all kinds of disabilities. In some States, only vocational rehabilitation and special education are administratively involved, while in others representation includes vocational education.

Most cooperative arrangements have brought about the development of vocationally-oriented curricula within the schools. All of them, however, provide comprehensive evaluation of the retarded young person's vocational rehabilitation potential, personal adjustment and pre-vocational training, counseling, on-the-job training and work experience; job placement, follow-up and related vocational rehabilitation case services. The number of retarded young people enrolled in cooperative vocational rehabilitation work-study programs is increasing steadily as new programs are developed. These cooperative programs have proven themselves effective in reducing the school dropout rate of retarded youngsters and have provided a technique for continuous service to youngsters during the school years when they are best able to benefit from them.

Another emphasis of State vocational rehabilitation agencies has been the establishment of rehabilitation facilities, such as comprehensive rehabilitation centers, evaluation centers, occupational training centers, workshops, half-way houses, and other specialized facilities serving the mentally retarded. Such a rehabilitation facility may be established by State rehabilitation agencies, or by the State agency in cooperation with other public or private agencies.

State vocational rehabilitation agencies may assist in the construction of rehabilitation facilities in a variety of ways. They may construct new buildings; alter, expand or renovate existing buildings; purchase necessary equipment; and provide initial staffing support. In all cases, State or private financial resources must be used to match Federal funds.

The program for Federal employment of the mentally retarded has been an outstanding success, with 7,442 placements in 116 different job titles at Federal installations across the country. The retention rate for these retarded employees has been far superior to that of other employees in similar jobs, and the program has become a part of the permanent personnel policy of the U.S. Civil Service Commission. State vocational rehabilitation agencies play a highly important role in this program in that they certify all retarded applicants as job-ready.

Special project grants for the innovation and expansion of vocational rehabilitation services have been utilized to extend and improve State rehabilitation agency efforts for the mentally retarded. Expansion grants are designed specifically to increase the number of people rehabilitated by the State agency. Within an extensive program of rehabilitation facility improvement, the Rehabilitation Services Administration administers facility improvement grants designed to upgrade the services of sheltered workshops and other facilities by supporting such activities as employment of additional staff, technical consultation, staff development, and the purchase of equipment. Facility improvement grants have been awarded to residential institutions for the mentally retarded to improve their sheltered workshop programs.

Other rehabilitation facility improvement activities are (1) a program of technical assistance consultation to provide workshops and other facilities with special consultation services in such areas as workflow, safety engineering, contract procurement, and vocational evaluation and adjustment; and (2) projects to share in the cost of providing training services for handicapped individuals in public or nonprofit workshops and rehabilitation facilities. Federal financial participation in the training services grant program may assist in the cost of such services as training in occupational skills, work evaluation, work testing and the provision of occupational tools and equipment necessary for training purposes and job tryouts.

Rehabilitation training in Mental Retardation has focused on rehabilitation counselor training by supporting field units in which student trainees can concentrate their practicum experience in work with this client population. Such grants also support field instructional faculty.

Rehabilitation, Research and Demonstrations

Accurate appraisal of the abilities of all clients falling within the rubric of the developmentally disabled is a crucial first step in the rehabilitation process leading to competitive employment, increased earnings and independent community living. The extension of rehabilitation services into the ghetto areas to reach more of the functionally retarded whose handicaps derive from social and cultural deprivatior makes the social, educational, and vocational training, which would most likely help a retarded or developmentally disabled individual achieve full participation in the economic and communal life of the country, a more subtle process requiring even more refined techniques. Precise evaluation of individual potentials and of the effectiveness of various rehabilitation approaches is an equally important prerequisite for development of innovative patterns of service to the profoundly retarded.

A comprehensive overview has been completed for types of training programs given the retarded throughout the United States and the environmental and personal characteristics that have contributed to their vocational adjustment. Similarly, a project studied the later social and vocational adjustment of 575 retarded individuals discharged from a training center over a 9-year period to determine those variables that facilitated their ability to get along in society. A satellite workshop program has demonstrated that several workshops in inner city areas were able to provide a variety of prevocational and vocational training experiences which they could not have provided separately.

Future projects will be concerned with improved delivery of services to retardates in model city neighborhoods, with the most effective mix of services to deinstitutionalize the mentally retarded, and with the development of techniques designed to place more effectively the developmentally disabled clients such as the epileptic and the cerebral palsied. Various projects, located in the communities, will demonstrate different ways of involving the parents and other family members in the rehabilitation process of the developmentally disabled and retarded client.

Rehabilitation Research and Training Centers

The Social and Rehabilitation Service supports selected demonstration projects that seek to coordinate group homes and other community resources for the mentally retarded. Particular attention is given to coordination between special education and vocational rehabilitation agencies. Rehabilitation Research and Training Centers for the mentally retarded study problems relating to the diagnosis, evaluation, treatment and training, vocational counseling and placement of the mentally retarded. Increased attention is being directed toward the developmentally disabled and the training of personnel involved with providing services to that population.

	(Dollars in Thousands)				
	1971	1972	1973	1974	1975 Est.
Rehabilitation Research and Demonstrations	507	1,230	750	800	800
Rehabilitation Research and Training Centers	243	935	600	600	600

Rehabilitation Services Administration

The Rehabilitation Services Administration is responsible for a broad range of programs designed to provide habilitation and rehabilitation services for the developmentally disabled including the mentally retarded. These programs cover support for planning, administration, services and the construction of community facilities through formula grants to States as well as support for project grants designed to reduce the resident population in large State institutions for the retarded by making available specialized community services and by increasing the use of generic services. Also included are grants for: Core support of interdisciplinary training programs in university-affiliated facilities for manpower needed for the training, care and treatment of the developmentally disabled; improvement of services in State residential facilities for those retarded who are appropriately placed; training of professional supportive and technical personnel already engaged in occupations involved in the care and rehabilitation of the developmentally disabled; planning and construction of rehabilitation facilities and sheltered workshops; special projects for expansion and innovation of vocational rehabilitation services.

These diverse activities are unified by the common goal of assisting the developmentally disabled, including the mentally retarded to achieve and maintain the maximum personal, social and economic independence of which they are capable. Underlying these activities is the continuing concern for expanding opportunities and resources available to the substantially handicapped among the developmentally disabled.

1. Developmental Disabilities

a. Formula Grants to States

The Title I, Part C of the Developmental Disabilities Services and Facilities Construction Act of 1970 (P.L. 91-517) which amended the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (P.L. 88-164) authorized formula grants to States for comprehensive planning, administration, services and construction for the developmentally disabled. The 1963 Act limited Federal support to facilities and programs for the mentally retarded. The 1970 Act extends support to include not only mental retardation but also cerebral palsy, epilepsy, and other neurological conditions approved by the Secretary. The Developmental Disabilities Act calls for Federal, State and local governments and voluntary agencies to share responsibilities for establishing and maintaining programs that will enable the developmentally disabled to: (1) enhance their physical, intellectual, and social capabilities to the fullest extent possible; (2) gain emotional maturity commensurate with social and intellectual growth; and (3) attain skills, habits, and attitudes essential to living a personally satisfying life.

Federal support is available for a wide range of diversified services in terms of life-time human needs of the developmentally disabled. The Act provides for the co-mingling of funds under this program with those of other State programs. This facilitates the development of comprehensive services for the developmentally disabled through the combination and integration of the efforts in both specialized and generic services of State agencies representing diverse areas such as health, welfare, education and rehabilitation, without imposing a set pattern of services on any one State.

Comprehensive planning of needed services and facilities providing for more efficient and effective utilization of existing human and fiscal resources at all levels is required. New or innovative programs will be developed to fill gaps in existing services and to expand the reach of existing services among new groups of individuals. Services and resources of all State, regional, and local agencies assisting the developmentally disabled will be integrated.

Responsibility is placed at the State level for developing strategies for the successful implementation of the program. Use of Federal funds must not result in a decrease in the level of effort at State and local levels in providing services to persons with developmental disabilities. To the extent feasible, this program should stimulate an increase in effort.

To receive Federal funds under the program, States must submit State Plans to the Regional Commissioner, SRS for approval. The State Plan must include a description of how other State-Federal programs provide for the developmentally disabled and how the new program will complement and augment, but not duplicate, these programs. At least 9 programs must be taken into account: vocational rehabilitation, public assistance, social services; crippled children's services, education for the handicapped, medical assistance, maternal and child health, comprehensive health planning and mental health.

Because of a correlation between poverty and developmental disabilities, a higher Federal share is provided for areas of urban-rural poverty. These higher rates of support offer new incentives to alleviate existing inequities.

The Federal share of services in nonpoverty areas was 75 percent in Fiscal Years 1971 and 1972, 70 percent for Fiscal Year 1973 and also for Fiscal Year 1974. In poverty areas Federal support for services is 90 percent for the first 24 months of a project and 80 percent for the next 12 months. For construction projects, the Federal share is up to 66-2/3 percent for nonpoverty areas and up to 90 percent for poverty areas.

In Fiscal Year 1973, $21,715,000 was appropriated for this program, and $30,875,000 in Fiscal Year 1974. The law permits the setting aside of up to 10 percent for projects of national significance. This percent was used in 1973, but in Fiscal Year 1973, 9 percent and in Fiscal Year 1974 approximately 5.2 percent were used for such purposes.

Of the Fiscal Year 1973 monies allotted to the States, 7.5 percent or $2,958,485 was used for administration, 7.9 percent or $2,141,159 for planning, 78.8 percent or $21,519,888 for services, and 5.8 percent or $1,584,241 for construction. This makes a total of $27,303,773, representing unspent funds from previous fiscal years in addition to the 1973 allotments. (Five States have not reported as of this writing and are not included in this summary).

The percent of allotments (omitting the 5 non-reporting States) spent for each service and the number of clients served by each are as follows:

Services	Percent	Individuals Served
Diagnostic	5.2	31,566
Evaluation	4.6	30,476
Treatment	7.4	48,504
Personal Care	5.2	2,262
Day Care	7.9	14,929
Domiciliary Care	13.4	806
Special Living Arrangements	8.5	3,188
Training	10.2	16,353
Education	5.6	25.554
Sheltered Employment	7.0	3,682
Recreation	4.2	14,663
Counseling	6.1	16,016
Protective and Socio-Legal	2.3	4,085
Information and Referral	5.4	54,968
Follow-along	4.0	8,588
Transportation	3.0	6,687

Total client/services provided* 282,327

*Many clients received multiple services.

Typical types of projects included:

Gasoline Service Station Training Program

This project is designed to provide a realistic opportunity for developmentally disabled persons to meet and serve customers, to make money change, and to work in the demanding atmosphere of serving the public. Work experience includes pumping gas, washing cars, changing oil, lubricating cars, and servicing new and used cars for automobile dealers in the area. Six clients were initially placed in the project. One is currently working as a service station attendant and five are working in other competitive occupations.

Coordinator to Assist Clergy

Funds were awarded to a private non-profit community agency to hire a coordinator to assist local churches and clergy in becoming involved in planning innovative services to the developmentally disabled people and their families.

Hostels for Severely and Profoundly Handicapped

Two developmental hostels for severely and profoundly retarded children with multiple physical handicaps now in State institutions were established. Each hostel will serve 3 children, prepare them in social skills (eating, dressing, toilet training, physical therapy, recreation and education).

Life Enrichment Program for Adults not Eligible for Workshops Placement

In one community within a State, a small segment of the adult cerebral palsied population are so severely handicapped physically that they do not qualify for existing programs. They are living at home generally with aging parents who find it increasingly difficult to provide a 24 hour a-day care. These individuals are potential residents in State or private residential care facilities within the foreseeable future. The Life Enrichment Program has removed the handicapped persons from the home on a scheduled basis three afternoons a week to an activity center thereby increasing their capability to live within their family environment.

Cooperative Areawide Transportation System

Nine public non-profit agencies have joined together to form the Cooperative Areawide Transportation System for the purpose of providing transportation services and programs to the developmentally disabled in a large metropolitan area. Future plans call for extending this service into an adjoining State. The services include transporting individuals to and from daily routine activities, special necessary services, special functions and occasions, and delivery of goods to sheltered workshops and activity centers.

Coordination with Other Agencies

The State Planning and Advisory Council was able to refer to other agencies four requests which came to it for funds. These projects were rewritten and expanded to provide better services to the developmentally disabled.

Coordinated Protective Service System

One State has developed a network of protective services including case management and personal advocacy. It represents a joint effort of public and private organizations. Originally projected for high priority areas only, it is now being implemented on a Statewide basis.

Special projects of national significance are designed to provide knowledge and information, technical assistance and evaluation which will improve the planning and delivery of services to the developmentally disabled. Ten projects were approved using Fiscal Year 1973 funds. They include:

1-5. Child Advocacy: The Division of Developmental Disabilities, Rehabilitation Services Administration has joined with the Bureau of Education for the Handicapped and the National Institute of Mental Health in comingling funds to support five child advocacy projects: The National Association for Retarded Children project catalyzes a nationwide volunteer child advocacy program. Peabody College established four general advocates in four rural counties in Tennessee. The Kentucky Commission on Children established State and regional advocacy offices. The National Easter Seal Society for Crippled Children & Youth aims to perfect a model of advocacy for physically handicapped children. And, the United Cerebral Palsy Association is developing three models of advocacy for developmentally disabled children and their families in three areas of the U.S. A.

6. Legal Advocacy: The Division of Developmental Disabilities, Rehabilitation Services Administration has joined with the Bureau of Education for the Handicapped in comingling funds to support a legal advocacy project at Notre Dame University. It includes a reference system for all national and State legislation on developmental disabilities; a reference system for all national, State, and local legal actions pertinent to the developmentally disabled; an electronic retrieval system for all data in the system; a research arm to study questionable issues pertinent to the legal rights of the developmentally disabled; and eleven other aims related to law.

7. Technical Assistance to State Councils for the Developmentally Disabled: At the University of North Carolina a technical assistance and consultation system has developed a strategy and organization to deliver technical assistance to State and territorial councils for the developmentally disabled, assisting them in their tasks, especially in planning and evaluation, but also including program management, information, and data collection and dissemination. A needs assessment survey is conducted prior to the provision of technical assistance in order to determine critical areas for technical assistance.

8. National Information and Individualized Data Base for the Developmentally Disabled: At the Pacific State Hospital (California) in association with UCLA, a pilot for a national information center and individualized data base has been established to develop an individualized tracking system, individual developmental assessment of progress through a continuum of services, evaluation of programs providing services to individuals, groups, and families, and derivation of a benefit-cost analysis on services rendered, including living arrangements. The project will fill the void that exists in terms of information about services and individuals in the national system.

9. National Conference of State Councils for the Developmentally Disabled: The Council for Exceptional Children conducted a national conference of State Councils with the National Advisory Council on Developmental Disabilities. The conference had as its aim an encouragement of a

fuller understanding and effective implementation of the Developmental Disabilities Act, provision of up-to-date technical information relative to the functions of planning and evaluation of services for the developmentally disabled, development and extension of communication between the National and State councils, and provision of a forum for discussion of issues related to the Developmental Disabilities Act, and its programs.

10. Deinstitutionalization, including institutional reform and community alternatives for the Developmentally Disabled: Fourteen grants were made to various agencies to demonstrate innovative ways of carrying out this objective, which will have generalizability to other locales. In addition, small grants were made to 47 States to develop long range plans for improving and reducing the population of institutions. These plans are to become part of the basic State Developmental Disabilities Plan. (3 States did not qualify.)

The initial staffing program under P.L. 90-170 will be substantial in the final year of Federal assistance in Fiscal Year 1974. This program supports professional and technical personnel in facilities for the mentally retarded. In 1974, the last year of the program, there are 100 projects which serve an estimated 23,000 persons. Grants were made on a declining basis for 51 months, the grants did not exceed 75 percent of the cost for the first 15 months, 60 percent for the next year, 45 percent for the third year, and 30 percent for the last 12 months.

b. University-Affiliated Facilities for the Developmentally Disabled

Under Title I, Part B of the Developmental Disabilities Services and Construction Act of 1970, the University-Affiliated Facilities for the Developmentally Disabled Program provides for Federal support for interdisciplinary training in institutions of higher learning as well as for the construction of facilities to house these programs. Grants may be made to cover the costs of administering and operating demonstration facilities and training programs for personnel needed to render specialized services to persons with developmental disabilities. In Fiscal Year 1973, $4,250,000 was made available for this program through continuing resolution. Grants were made to the facilities listed below to partially fund expenses of administration and operation.

Among the professional disciplines trained in these facilities are medical personnel, dentists, nurses, speech and hearing therapists, nutritionists, physical therapists, occupational therapists, rehabilitation specialists, special educators, psychologists, social workers, recreational specialists and chaplains. Each facility is encouraged to conduct a comprehensive program so that each discipline involved in the habilitation and rehabilitation of the developmentally disabled may be fully familiar with the contributions of the other disciplines.

Approved projects for administering and operating demonstration and training programs in university-affiliated facilities for the developmentally disabled are: Children's Hospital Medical Center, Boston, Massachusetts; Walter E. Fernald State School, Waltham, Massachusetts; Newark State College, Union, New Jersey (now Kean College of New Jersey); Albert Einstein College of Medicine, Bronx, New York; New York Medical College, New York, New York; New York Medical College, Valhalla, New York; Georgetown University, Washington, D.C.; Johns Hopkins, Baltimore, Maryland; Temple University, Philadelphia, Pennsylvania; University of Alabama (Birmingham), Birmingham, Alabama; University of Alabama (Tuscaloosa), Tuscaloosa, Alabama; University of Miami, Miami, Florida; Georgia Retardation Center (Atlanta), Atlanta, Georgia; Georgia Retardation Center (Athens), Athens, Georgia; University of North Carolina, Chapel Hill, North Carolina; University of Tennessee, Memphis, Tennessee, University of Kentucky Center for the Handicapped, Lexington, Kentucky; Indiana University, (Bloomington), Indiana; Indiana University (Indianapolis), Indianapolis, Indiana; The University of Michigan, Ann Arbor, Michigan; University of Cincinnati,

Cincinnati, Ohio; Ohio State University, Columbus, Ohio; University of Wisconsin, Madison, Wisconsin; Louisiana State University, New Orleans, Louisiana; University of Iowa, Iowa City, Iowa; University of Nebraska, Lincoln, Nebraska; Meyer Children's Rehabilitation Inst., Omaha, Nebraska; University of Kansas (Lawrence), Lawrence, Kansas; University of Kansas (Kansas City), Kansas City, Kansas; University of Kansas (Parsons), Parsons, Kansas; St. Louis University, St. Louis, Missouri; University of Missouri, Columbia, Missouri; University of Colorado, Denver, Colorado; University of South Dakota, Vermillion, South Dakota; Utah State University, Logan, Utah; University of California (Los Angeles), Los Angeles, California; Children's Hospital of Los Angeles, Los Angeles, California; University of California (Irvine), Irvine, California; University of Oregon (Eugene), Eugene, Oregon; University of Oregon (Portland), Portland, Oregon; and the University of Washington (Seattle), Seattle, Washington.

c. Project Grants for Rehabilitation of the Developmentally Disabled

Project grants administered by the Division of Developmental Disabilities under the provisions of Section 304(b)(1) of the Vocational Rehabilitation Act pay part of the cost of organized, identifiable activities which will contribute to the vocational rehabilitation of severely disabled developmentally disabled persons. These services will include a wide range of services necessary to help the disabled to obtain, keep, and advance in employment. Many substantially handicapped with developmental disabilities will become eligible for these services. In order to retool for this effort, demonstrations will be necessary to attack the wide variety of problems inherent in these changes.

First Priority

Greatest priority should be given to the primary vocational rehabilitation processes which will need to be adapted to the needs of the more severely handicapped, such as evaluation techniques, equipment adaptation, and personal counseling approaches.

Other such areas as approaches for overcoming attitudinal barriers of employers, fellow-employees and cost differential studies of the delivery of these discrete services are most needed.

Other priority needs for demonstration may be in the area of housing, transportation, follow-along, and recreation (leisure time activities which are sometimes necessary adjuncts to successful rehabilitation).

d. Mental Retardation Hospital Improvement Program

The Mental Retardation Hospital Improvement Grant Program is designed to assist State institutions for the mentally retarded to improve their care, treatment, and rehabilitation service. The program is specifically focused on the demonstration of improved methods of services and care, as opposed to research exploration or the development of new knowledge.

The ultimate intention of improving instiutional services is to increase the number of residents to be either readied for return to the larger community or to become less dependent through improved habilitation approaches.

These funds will be used to demonstrate means of bringing units identified as "potential" ICF's up to the Medicaid standards; or to develop innovative strategies to bridge residents from institutional to community life and/or assist personnel to better serve such residents; or to retrain attendant personnel in improved methods of habilitation for the severely retarded and multiply handicapped resident.

Office of Planning, Research and Evaluation

International research in mental disabilities complements the domestic programs by emphasizing non-institutional rehabilitation of the mentally retarded, mentally ill and developmentally disabled. A number of countries including India, Pakistan, Egypt, Poland and Tunisia, are concerned with studying new methods and techniques for the diagnosis, evaluation, treatment, training and vocational placement of this increasing population with multiple needs. Day care programs in India and Poland, supplemented by training of mothers, have been successful in complementing other programs to promote the adjustment of mental retardates in the community. Half-way Houses in Pakistan are also indicative of the family and the community's concern of adults with mental illness. Increased concern is now being directed to the mentally retarded and the developmentally disabled.

	(Thousands of Dollars)				
	1971	1972	1973	1974	1975
Special Foreign Currency Program.................	$395	$347	$200	$300	$300

Purpose

The basic purpose of the social insurance programs (Old-Age, Survivors, Disability, and Medicare) is to provide cash benefits to replace, in part, earnings that are lost to individuals and families when earnings stop or are reduced because the worker retires, dies, or becomes disabled, and to provide health insurance protection to persons 65 and over and to the disabled under certain conditions. This part of the program is contributory and self-supporting. Benefits are wage-related and entitlement to benefits is an earned right. Another program (Supplemental Security Income) recently added to those SSA administers provides payments to the needy aged, blind, and disabled, is noncontributory and is financed entirely out of general Federal revenues.

Historical Development

In 1935, when the original social security law was passed, the program was to have provided only retirement benefits to aged workers. In 1939, benefits for dependents and survivors were added and benefits became payable in 1940. Protection against long-term total disability--not only for disabled workers, but also for adult sons or daughters (who became disabled before age 18) of disabled, retired, or deceased workers--was provided by the 1956 amendments. In 1965, health insurance benefits for the aged were added. The 1967 amendments provided benefits for disabled widows and widowers age 50 and over. Since 1949, there have been eight general benefit increases in recognition of the fact that prices and wages have gone up. In 1972 a section of P.L. 92-336 provided for an automatic benefit increase when the cost-of-living rises by 3 percent or more. Effective January 1974, payments under the Supplemental Security Income Program began to qualified aged, disabled, and blind persons, including the mentally retarded.

Economic Impact

Under Title II Programs (Old-Age, Survivors, and Disability)
Mental deficiency is a major factor in more than 65 percent of cases involving dependents or survivors who have been continuously disabled since childhood. It is the primary diagnosis in about half of all childhood disability cases. In fiscal year 1973, an estimated 198,200 mentally retarded adults disabled in childhood and retarded workers received $237.25 million in benefits.

The regulations contain guides as to the level of severity required in disability cases involving mental retardation. These regulations (published in 1968) have the effect of law and are available to the public and the medical community.

The number of mentally retarded children under age 18 who receive social security insurance payments as dependents of retired, disabled, or deceased workers is unknown, since their benefits are payable regardless of disability.

Under social security's "Childhood Disability" provisions, lifetime monthly payments can be made to a person age 18 or over who has been disabled by mental retardation--or other impairments--since childhood. In many cases, the monthly benefits enable the retarded childhood disability beneficiary to be cared for at home instead of in an institution. Furthermore, as more and more retarded people outlive their parents, the program offers reassurance to fathers and mothers who know that financial help for their disabled child will be forthcoming even after their death. About half of the childhood disability beneficiaries are over 35 and 25 percent of them are over 45.

If the parents are dead, a relative who has demonstrated a continuing interest in the beneficiary's welfare, a welfare agency, or a legal guardian may be chosen as representative payee to handle the benefit funds and plan for using them in behalf of the beneficiary. A representative payee receives social security benefits in trust for the beneficiary and, as a trustee, is held accountable for the way in which he uses the benefits.

Under Title XVIII

Medicare benefits are available to any individual, including a mentally retarded individual, who is 65 or over and who meets certain necessary conditions. Therefore, a mentally retarded individual 65 years of age who has contracted an illness or suffered an injury is, like any other person in this age group, protected under the Medicare program. (However, the Medicare program does not provide coverage of non-medical care such as personal care, vocational training, etc.) Beginning July 1, 1973, Medicare benefits were also extended to social security disability beneficiaries, under 65 years of age, who have been receiving disability benefits for 24 consecutive months.

Under Title XVI

An estimated 227,700 retarded individuals who are not entitled to benefits under the Title II Disability Insurance Program will be receiving payment under the Supplemental Security Income Program by the end of fiscal year 1974.

Activities and Achievements

Since 1970, the Social Security Administration has conducted biennial on-site reviews in State mental hospitals and schools for the retarded. The program focus is an in-depth examination of the way in which these institutions are managing social security benefits on behalf of patients who receive their checks through an institutional official serving as "representative payee."

The observations and conclusions resulting from a State review are, after analysis, communicated to the State Commissioner for his use in the development of improved practices in the State's system. Findings also serve as a basis for SSA program and policy evaluation. The on-site approach is expected to strengthen relationships with the States, improve their understanding of their responsibility for optimum use of benefits when serving as representative payee, and open new channels for the discussion of problems and practices affecting the well-being of all beneficiary-patients in State mental institutions.

SSA has participated in the program to employ the mentally retarded since its inception in 1964. It has also tried to generate interest in the program by private employers and other Federal agencies. In SSA retardates are successfully performing in such positions as mail and file clerks, messengers, operators of printing, xerox, card reader machines, and key punch machines. The SSA experiment with the color coding of file cabinets and cartridges of microfilm has proven highly successful in broadening the employment opportunities for retardates to an area of work which requires a very high degree of accuracy. The retardates have performed their duties in an excellent manner.

The Social Security Administration has published a leaflet entitled If You Become Disabled. A number of others are in stages of preparation or revision.

The color film, "Where There is Hope," which tells of the social security benefits available for the adult child, continues to be distributed through district offices for theatrical and general showing. It is also offered to State associations for retarded children. It depicts teenagers and older people at work in a sheltered workshop in Washington, D.C., diagnosis and therapy at the John F. Kennedy Institute in Baltimore, and the trial work period of a beneficiary in Greensboro, North Carolina.

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In cooperation with the Bureau of the Census, the Social Security Administration conducted surveys in 1971 and 1972 of noninstitutionalized adults who had been reported as disabled in the 1970 Census or had become disabled since the 1970 Census. The data collected included demographic characteristics; employment history and present work situation; disabling conditions; job limitations and adjustment; functional limitations and mental health ratings; use of medical care and rehabilitation services; family participation and relationships; and economic resources. Mentally retarded persons age 18 and over who were not institutionalized at the time of the survey are included in these studies. Reports summarizing the data will become available in 1974 and 1975.

SURPLUS PROPERTY PROGRAM

The Office of Surplus Property Utilization, Office of Facilities Engineering and Property Management, within the Office of the Assistant Secretary for Administration and Management, carries out the responsibilities of the Department under the Federal Property and Administrative Services Act of 1949, as amended, which makes surplus Federal real and personal properties available for health and educational purposes. The properties which become available under this program are those that have been determined by the General Services Administration as having no further Federal utilization.

Surplus personal properties generating at Federal installations in the United States, Europe and Southeast Asia, are screened to determine those which may be needed and usable by eligible institutions throughout the Country in conducting health and educational programs. Properties determined to have such need and usability are allocated by the Department of Health, Education, and Welfare for transfer to State Agencies for Surplus Property which have been established in all States. These State Agencies secure the properties, warehouse them, and make the distribution to eligible donees for health and educational uses within their respective States. The only costs to the eligible donees are the handling and service charges which are assessed by the State Agencies.

In the case of real properties which have been determined to be surplus to Federal needs, notices of their availability are sent to potentially eligible applicants, either by the State Agencies or the Assistant Regional Directors for Surplus Property located in our ten regional offices. Real properties available for removal from their site for relocation are conveyed by agreement of sale with restrictions as to the use of the facilities, which run for a period of 5 years. These properties are conveyed with a 100 percent public benefit allowance applied against the sales price. Land, or land and buildings together with other improvements, are conveyed by deed which contains restrictions as to use for a period of 30 years. These properties are conveyed with public benefit allowances ranging up to 100 percent applied against the sales price. The only other costs to eligible transferees are "out-of-pocket" Federal costs, i.e., appraisals, surveys, etc.

Schools for the mentally retarded are eligible to acquire surplus real and personal property. In the case of personal property, such a school must be operated primarily to provide specialized instruction to students of limited mental capacity. It must be tax-supported or nonprofit and exempt from taxation under Section 501(c)(3) of the Internal Revenue Code of 1954. It must operate on a full-time basis with a staff of qualified instructors for the equivalent of a minimum school year prescribed for public school instruction of the mentally retarded. It must also demonstrate that the facility meets the health and safety standards of the local governmental body.

An applicant for real property must be a State, or a political subdivision or instrumentality thereof; a tax-supported educational or public health institution; or a nonprofit educational or public health institution which has been held to be exempt from taxation under Section 501(c)(3) of the Internal Revenue Code of 1954. Its proposed program of use must be fundamentally for an educational or public health purpose; i.e., devoted to academic, vocational or professional instruction, or organized and operated to promote and protect the public health. Real property may be put to a joint use, namely, for the training of the mentally retarded as well as the physically handicapped. Conveyances have been made for hospital use where, as a part of the total program, portions of the facility are used for the treatment and training of the mentally retarded.

Available personal property may range anywhere from a nail to an electronic computer. Many items have never been used before. Real properties may consist of all types of buildings which are removable, land with or without structures and other improvements--such as utility lines, sewer and water systems, etc.

Pamphlets giving more detailed information as to eligibility of organizations for both surplus real and personal property, as well as additional information in connection with the Surplus Property Utilization Program, and a directory of the State Agencies for Surplus Property and the ten Regional Offices of the Department, may be obtained from the Office of Surplus Property Utilization, Department of Health, Education, and Welfare, Washington, D. C. 20201.

Many States have passed special legislation which requires establishment of special schools for the retarded, and many such facilities are located on former surplus property. In Missouri, the State Department of Education operates a day school with a current enrollment of 121 children (ages 6-20). The State Department of Public Health and Welfare operate the Springfield Regional Diagnostic Clinic which serves over 1,000 patients in a 16 county area. Both of the facilities are located at the former VA O'Reilly General Hospital.

The State of Florida established the system of the Sunland Training Center throughout the State. The Center at Marianna is located at the former Graham AFB site.

The State of Georgia obtained the former VA Domiciliary in Thomasville, consisting of 207 acres of land and 131 buildings, with a bed capacity of 400 to 800, for the care and rehabilitation of the mentally ill and retarded. Another site of nearly 200 acres, at the former U. S. Penitentiary Honor Farm near Atlanta, has been conveyed for a Regional Mental Hospital for the rehabilitation and training of the mentally ill and retarded.

In 1966, the State of Ohio received the former VA Hospital at Broadview Heights, near Columbus. It is now known as the Broadview Center for the Mentally Retarded; inpatient service began in 1968. During the year, 580 patients applied for service. Now, after eight years of operation, the Center maintains a staff of 230, and is expanding its facilities by the construction of new buildings and cottages where patients live in a homelike atmosphere prior to their release.

Many programs are operated by other than States, such as counties, local school boards, and associations for the retarded. In Louisiana, during the past year, the Terrebonne Association for Retarded Children acquired 20 acres and 19 housing units at the former Houma AFB, for use as residential, day care, and training center for the retarded. Orleans Parish School Board acquired a portion of the U. S. Quarrantine Station at New Orleans for the education and training of retarded.

In Washington, the Northwest Center for the Retarded, a nonprofit corporation, has received two separate parcels of land and facilities at the former Naval Supply Depot, Puget Sound. This Center provides education, specialized training and related service to students who are ineligible for any community or public school program. The goal is to develop skills necessary for students to participate in existing public school classes, workshops, or as contributing members of society. No student is turned away because of his handicap nor because the family is unable to pay. In addition, the Walla Walla County Board of Commissions has received a small parcel of land and two buildings at the Walla Walla Ranger Station, Washington, for use in training mentally retarded and handicapped.

The Harrison County Board of Education, Mississippi received approximately 10 acres of surplus land at the VA Hospital Reservation, Biloxi on which to construct a school for the physically and mentally handicapped. The school, designed to serve approximately 200 students, has been completed and now provides education to the physically and mentally handicapped children of school and preschool age of Harrison County and three nearby counties. While the school does serve educable students, the vast majority are of the trainable classification. This specialized school for the physically and mentally handicapped began operation in September 1970 with 160 students. Due to the severity of involvement and multitude of handicaps, the maximum enrollment is presently 250--ranging in age from 3-20 for those attending on a full-time basis, and from birth to 21 for those attending on a part-time basis.

In New York three transfers of real property were made in FY 73 for these programs. The Board of Cooperative Educational Services, Eric County, received a 20 acre portion of the former nike battery NY-18 installation for use in special and vocational training and education of the handicapped, including the retarded and emotionally disturbed. A portion of Brookhaven National Laboratory, consisting of approximately 11 acres of land, will be the site of a school for the retarded operated by the New York State Association for Retarded Children, Suffolk County. Also a 2 acre portion of the former Manhattan Beach Public Health Service property, Sheepshead Bay, was conveyed to the Association for the Help of Retarded Children as the site of a school for the severly retarded.

Through June 30, 1973, [illegible]368.79 acres of land and 872 buildings have been transferred to institutions for use in programs serving the mentally retarded. These properties originally cost the Government $49,025,812 and had a fair market value of $20,509,085 at the time of transfer.

Schools for the mentally retarded operated by State and local agencies of government, as well as many nonprofit schools operated by Associations for the Mentally Retarded or Cerebral Palsy, are major users of surplus personal property acquired through the State Agency Distribution Center of their State. During FY 73, surplus personal properties having an original acquisition cost of $318,618,889 were donated to eligible public health, educational and civil defense donees in the States. Representatives of schools for the mentally retarded should establish their school's eligibility with their State Agency and make regular visits to their State Agency Distribution Center(s) to inspect available properties and select items needed by their school.

APPENDIX

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Obligations for Mental Retardation Activities

Fiscal Years 1973-1975
(Thousands of Dollars)

ACTIVITY	1973	1974 Revised Budget Estimate	1975 Budget Estimate
OFFICE OF EDUCATION			
Services			
Title I, ESEA, Educationally Deprived Children	$46,400	$47,000	$ 1/
Title II, Library Resources	1.350	1,500	1/
Title III, Supplementary Centers	8,200	8,200	1/
Education for the Handicapped Act, Part B	10,566	10,600	1/
Education for the Handicapped Act, Part C, Section 623	988	988	1,000
Education for the Handicapped Act, Part F	3,000	3,000	3,000
Vocational Education Act, Part B	19,000	20,000	1/
Total, Services	89,504	91,288	4,000
Training			
Education for the Handicapped Act, Part D	10,920	10,920	10,920
Education Professions Development Act 1/	1,400	---	---
Total, Training	12,320	10,920	10,920
Research			
Education for the Handicapped Act Part E	3,104	3,000	3,000
Total, Research	3,104	3,000	3,000
Other			
Library Services and Construction Act	69	80	37
Total, Other	69	80	37
TOTAL, OFFICE OF EDUCATION	$104,997	$105,288	$17,957

1/ These programs are being consolidated in fiscal year 1975 into a consolidated education grants legislative proposal. While no dollar amounts are available on estimated 1975 spending on mental retardation under the new proposal, OE anticipates the States will spend up to 1974 levels.

ACTIVITY	1973	1974 Revised Budget Estimate	1975 Budget Estimate
PUBLIC HEALTH SERVICE			
Services			
Health Services			
Maternal and Child Health Services (Section 511, Title V, SS Act)	$ 6,988	$ 6,988	$ 6,988
Crippled Children's Services (Section 511, Title V, SS Act)	6,002	6,002	6,002
Preventive health services			
Disease Control (P.L. 91-695 & 93-151)	7,805	7,255	7,341
Total, Services	$ 20,795	$20,245	$20,331

ACTIVITY	1973	1974 Revised Budget Estimate	1975 Budget Estimate
PUBLIC HEALTH SERVICE (Continued)			
Training			
Health Services			
Training for Health and Related Care of Mothers and Children (Section 511, Title V, SS Act)	$ 1,600	$ 1,600	$ 1,600
Maternal and Child Health Services (Section 511, Title V, SS Act)	2,998	2,998	2,988
Crippled Children's Services (Section 511, Title V, SS Act)	1,341	1,341	1,341
National Institutes of Health			
National Institute of Neurological Diseases and Stroke	1,487	1,866	1,632
National Institute of Child Health and Human Development	1,333	2,408	1,914
Alcohol, drug abuse, and mental health			
Mental health (Section 303, PHS Act) . .	496	774	395
Total, Training	$ 21,512	$ 23,244	$ 22,137
Research			
Health services			
Research relating to Maternal and Child Health and Crippled Children's Services (Section 511, Title V, SS Act)	$ 1,600	$ 1,600	$ 1,600
National Institutes of Health			
National Institute of Neurological Diseases and Stroke	4,835	5,090	5,185
National Institute of Child Health and Human Development	17,883	18,921	18,179
Alcohol, drug abuse, and mental health			
Mental Health (Section 301, PHS Act) . .	979	1,090	1,006
Total, Research	$ 25,297	$ 26,701	$ 25,970
Other			
Health resources			
Health Care Facilities (Title VI, PHS Act)	$ 1,236	$ 1,300	---
Total, Other	$ 1,236	$ 1,300	---
TOTAL, HEALTH SERVICES ADMINISTRATION	$ 68,840	$ 71,490	$ 68,438
SOCIAL SECURITY ADMINISTRATION			
Income Maintenance			
Estimated Benefit Payments from RSI-DI Trust Funds	$237,250	$269,750	$330,850
Trust Fund Obligations Incurred to Adjudicate Claims of Beneficiaries . . .	3,559	4,406	4,963
Health Insurance			
Estimated Payments from HI Trust Fund . .	---	25,000	32,680
Estimated Payments from SMI Trust Fund . .	---	7,100	12,980
Trust Fund Obligations Incurred to Process Health Insurance and Supplementary Medical Insurance Claims	---	1,612	2,191
Total, Trust Funds	$240,809	$307,508	$383,664

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ACTIVITY	1973	1974 Revised Budget Estimate	1975 Budget Estimate
SOCIAL SECURITY ADMINISTRATION (Continued)			
General Funds			
General Fund Payments for Supplementary Income	$ ---	$144,324	$309,368
General Fund Obligations Incurred to Adjudicate Claims for Supplementary Security Income	---	8,659	18,562
Total, General Funds	---	$152,983	$327,930
TOTAL, SOCIAL SECURITY ADMINISTRATION	$240,809	$460,491	$711,594
SOCIAL AND REHABILITATION SERVICE			
Services			
Rehabilitation Services			
Grants to States, VR Act, Sec. 110	$ 68,817	$ 72,450	$ 77,050
Innovation Grants, VR Act, Sec. 120	---	---	---
Expansion Grants, VR Act, Sec. 120	100	100	---
Facility Improvement Grants, VR Act, Sec. 302(b)(c)	3,150	2,530	2,440
Services for the Developmentally Disabled			
Formula Grants for the Developmentally Disabled (P.L. 91-517, Sec. 131) 1/	21,369	28,530	25,157
Hospital Improvement, PHS Act, Sec. 303	2,986	4,477	5,977
Initial Staffing (P.L. 88-164, Sec. 141)	3,384	1,500	---
Project Grants, VR Act, Sec. 304(b)(1)	7,494	8,275	12,500
Social Services, SS Act	214,780	233,150	258,875
Medical Assistance, Title XIX, SS Act	380,000	420,000	490,000
Total, Services	$702,080	$771,012	$871,999
Research			
Research and Demonstrations, VR Act, Sec. 202(a)	$ 750	$ 800	$ 800
Research and Training Centers, VR Act, Sec. 202(b)	600	600	600
Social and Rehabilitation Activities Overseas (Special Foreign Currency Program)	200	300	300
Total, Research	$ 1,550	$ 1,700	$ 1,700
Training			
Services for the Developmentally Disabled VR Act, Sec. 304(b)(1) - Project Grants	$ 3,826	$ 4,225	$ ---
Hospital Improvement, PHS Act, Sec. 303	810	23	23
Construction			
University-Affiliated Facilities for the Developmentally Disabled	$ 31	$ ---	$ ---
Developmental Disabilities Formula Grant 1/	1,584	1,118	1,118
Total, Construction	$ 1,615	$ 1,118	$ 1,118
Income Maintenance			
Grants to States for Public Assistance			
Aid to Permanently & Totally Disabled	$236,639	$127,245 2/	$ 523 3/
Total, Income Maintenance	$236,639	$127,245	$ 523

ACTIVITY	1973	1974 Revised Budget Estimate	1975 Budget Estimate
SOCIAL AND REHABILITATION SERVICE (Continued)			
Other			
Services to the Developmentally Disabled University-Affiliated Facilities Demonstration Grants (P.L. 91-517, Title II)	$ 4,433	$ 4,335	$ 4,250
Formula Grants for Developmentally Disabled (Planning & Administration, P.L. 91-517, Sec. 131) 1/	5,305	5,100	4,600
Total, Other	$ 9,738	$ 9,435	$ 8,850
Total, Grants and Services	719,781	787,547	883,690
Total, Income Maintenance	236,639	127,245	523
TOTAL, SOCIAL AND REHABILITATION SERVICE	$956,420	$914,792	$884,213

1/ Funds authorized under P.L. 91-517 are obligated for programs in the areas of mental retardation, cerebral palsy, epilepsy and other neurological conditions closely related to mental retardation or requiring treatment similar to that required for mentally retarded persons. The reporting system that provides program data for this authority does not indicate the extent of participation of any one of these conditions. The funds are used for mental retardation as well as other categories that are defined as developmental disabilities. Estimates for mental retardation only are therefore not available; the amounts shown in the accompanying table are the total obligations for developmental disabilities. It is assumed that since the emphasis of the program, according to the definition, is on mental retardation, a substantial portion of the funds are expended in the area of the severely handicapped mentally retarded.

2/ Six months for all except Guam, Puerto Rico and Virgin Islands.

3/ Guam, Puerto Rico and Virgin Islands only.

OFFICE OF THE SECRETARY

Services			
Office of Child Development - Head Start	$ 6,000	$ 8,000	$ 8,000
Other			
Office of Mental Retardation Coordination	$ 179	$ 200	$ 200
President's Committee on Mental Retardation	635	656	656
TOTAL, OFFICE OF THE SECRETARY	$ 6,814	$ 8,856	$ 8,856
Total, Grants and Services	$900,432	$973,181	$978,941
Total, Income Maintenance	477,448	587,736	712,117
GRAND TOTAL, ALL FUNDS	$1,377,880	$1,560,917	$1,691,058

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

ACTIVITIES SERVING OLDER AMERICANS

1973

In response to the many social, health, economic, educational, and other needs of the Nation's older Americans, a wide range of programs serving this population was administered during 1973 by various agencies throughout the Department of Health, Education, and Welfare. This report describes, in the following order, the activities of agencies which administer the major programs serving older Americans. The report begins with a tabular summary of actual and expected yearly expenditures in conducting these agencies' activities.

I. Office of Human Development

   A. Administration on Aging

II. Social Security Administration

III. Public Health Service

   A. Health Services Administration

   B. National Institute of Child Health and Human Development, National Institutes of Health

   C. Alcohol, Drug Abuse, and Mental Health Administration

   D. Health Resources Administration

IV. Social and Rehabilitation Service

   A. Assistance Payments Administration

   B. Community Services Administration

   C. Medical Services Administration

   D. Office of Planning, Research, and Evaluation

   E. Rehabilitation Services Administration

V. Office of Education

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Funds for Programs on Aging

(In thousands of dollars)

	1971 Actual	1972 Actual	1973 Actual	1974 Estimate	1975 Estimate
I. Administration on Aging					
A. Development of programs for the Aging	15,700	44,552	83,637	306,136	195,600
B. Aging research and training	5,800	12,500	12,100	16,500	7,000
Total, Administration on Aging............	21,500	67,052	95,737	322,636	202,600
II. Social Security Administration					
A. Benefit payments to persons age 65 and over from Social Security trust funds:					
1. Disability insurance benefits (dependents)..............................	14,000	17,000	21,000	24,000	30,000
2. Retirement and survivors' insurance benefits................................	24,773,000	27,165,000	33,247,000	38,111,000	44,160,000 1/
3. Hospital insurance benefits................	5,442,000	6,108,000	6,648,000	7,215,000	8.197,000
4. Supplementary medical insurance benefits................................	2,035,000	2,255,000	2,391,000	2,611,000	2,937,000
Sub-total, benefit payments to persons age 65 and over from social security trust funds...........	$32,264,000	$35,545,000	$42,307,000	$47,961,000	$55,324,000 1/
B. Payments to persons age 65 and over from Federal Funds:					
1. Supplemental Security Income payments......	--	--	--	822,000	2,140,000
2. Special benefits for disabled coal miners................................	206,000	271,000	612,000	644,000	604,000
Sub-total, payments to persons age 65 and over from Federal funds...........	206,000	271,000	612,000	1,466,000	2,744,000
Total, Social Security Administration..	$32,470,000	$35,816,000	$42,919,000	$49,427,000	$58,068,000

2

1/ Includes effect of proposed legislation which would limit the retroactivity of actuarially reduced monthly benefits under the retirement, survivors and disability insurance programs. This legislation is estimated to reduce benefits to the age by $22,000,000 in 19..

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Funds for Programs on Aging

(In thousands of dollars)

	1971 Actual	1972 Actual	1973 Actual	1974 Estimate	1975 Estimate
III. Public Health Service					
A. Health Services Administration					
1. Community Health Service	$31,552	$30,502	$31,431	$26,106	$20,877
2. Quality Assurance	4,519	4,719	4,719	5,613	5,774
3. Professional Standards Review Organization	---	---	4,475	33,670	57,900
Subtotal, Health Services Administration	36,071	35,221	40,625	65,389	84,551
B. Center for Disease Control	---	10	---	---	---
C. National Institute of Child Health and Human Development	9,313	12,505	12,650	17,040	13,855
D. Alcohol, Drug Abuse, and Mental Health Administration					
National Institute of Mental Health	3,920	4,516	2,894	3,585	2,484
E. Health Resources Administration					
1. National Center for Health Statistics	---	926	10	872	1,100
2. Bureau of Health Resources Development, Health Care Facilities Service	68,920	61,240	41,762	48,881	60,403
3. Bureau of Health Services Research	9,774	10,133	5,396	5,322	5,322
Subtotal, Health Resources Administration	78,694	72,299	47,168	55,075	66,825
Total, Public Health Service	127,998	124,551	103,337	141,089	167,715

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Funds for Programs on Aging

(In thousands of dollars)

	1971 Actual	1972 Actual	1973 Actual	1974 Estimate	1975 Estimate
IV. Social and Rehabilitation Service					
A. Assistance Payments Administration	$1,592,779	$1,297,519	$1,287,752	$635,409	$25,707
B. Community Services Administration	83,794	170,000	216,000	268,000	280,000
C. Medical Services Administration	1,554,096	1,778,348	1,539,398	2,058,232	2,399,060
D. Office of Planning, Research and Evaluation	642	280	125	138	25
E. Rehabilitation Services Administration	8,764	9,214	9,008	9,634	9,524
Total, Social and Rehabilitation Service	3,240,075	3,255,361	3,052,283	2,971,413	2,614,316
V. Office of Education					
A. Research and Training	78	None	None	None	None
B. Library Resources	840	1,015	550	750	450
C. University Community Services	215	121	130	130	None
D. Adult Basic Education	1,346	1,534	1,800	1,800	None[1]
E. National Institute of Education	None	4,835	None	None	None
Total, Office of Education	2,479	7,505	2,480	2,680	450

1. No funds are requested in the Budget for Adult Basic Education as a separate program, since the Administration proposes to meet this need in a new proposed consolidated education grant program, which would give States and localities greater flexibility in the use of Federal funds for education.

I. OFFICE OF HUMAN DEVELOPMENT

A. THE ADMINISTRATION ON AGING (AoA)--CALENDAR YEAR 1973

A number of important developments for the Administration on Aging occurred in 1973, the most significant of which was the signing by the President on May 3, 1973 of P.L. 93-29, the "Older Americans Comprehensive Services Amendments of 1973".

On April 1, 1973, by order of the Secretary, AoA was transferred from the Social and Rehabilitation Service, (SRS) of which it had been a component since the SRS was created in 1967, to the new Office of Human Development, (OHD) in the Office of the Secretary. Since its creation effective on that date, OHD has been headed by the first Assistant Secretary for Human Development, Hon. Stanley B. Thomas, Jr.

Another change effective April 1 was the departure of John B. Martin, who had resigned as Commissioner on Aging, in which capacity he had served since mid-1969. Shortly thereafter, President Nixon and Secretary Weinberger announced the nomination of Dr. Arthur S. Flemming as Commissioner Martin's successor. Dr. Flemming was confirmed by the Senate, without opposition, and was sworn in as the third Commissioner on Aging on June 19, 1973.

1. STATE AND COMMUNITY PROGRAMS ON AGING

Throughout most of 1973 the Title III State and Community Program on Aging continued to function under authorization of the Older Americans Act as amended in 1969. The year 1973 may be viewed overall as a period of significant transition in the area of State and Community aging programs, toward more comprehensive planning and coordination of aging resources in order to lay the necessary groundwork for timely implementation of the new Title III State and Community Program, once new amendments were enacted. The President on May 3, 1973 signed into law the Older Americans Comprehensive Services Amendments of 1973. Title III of these amendments has as its objective the development of a comprehensive and coordinated system for the delivery of services to older persons at the State and sub-State levels.

Prior to the Amendments of 1973, the Older Americans Act provided support for discrete services designed to respond to particular needs of older persons in scattered local communities. Under the 1969 Amendments, a program of Areawide Model Projects had been initiated to test the viability of providing a network of coordinated service systems to serve older persons. Building upon the most successful experiences of these programs, the 1973 Amendments were designed to begin the development of a national initiative directed toward providing comprehensive and coordinated service systems for older persons, with great stress placed upon enhancing the capability of State and sub-State agencies to plan and implement programs that will increase the utilization of available and potential services and resources on behalf of older persons.

a. State Planning

In anticipation of the passage of new amendments to the Older Americans Act, State Agencies on Aging undertook State-wide surveys of their aging population to determine concentrations of older persons with the greatest social and economic need and to assess the availability of resources to meet the identified needs. Some State Agencies on Aging divided their States into planning and service areas in preparation for development, within areas of highest priority, of action plans for promoting comprehensive and coordinated systems of service for aging persons. Concomitantly, State Agencies on Aging began to build up their staffs and to develop overall staff capacity through training programs in preparation for the greatly expanded responsibilities which they were shortly to assume.

The overall objective of the new Title III program is to strengthen or to develop at the State or area level a system of coordinated and comprehensive services for older persons -- services which will enable older persons to live in their own homes or other places of residence as long as possible.

In order to achieve this objective, the program is designed to strengthen State Agencies on Aging in the discharge, among others, of the following responsibilities:

. to become the focal point in the State on behalf of older persons

. to carry out those activities necessary for effective planning on behalf of older persons, including the establishment of measurable objectives for aging programs

. to establish such procedures and mechanisms as are necessary to assure the effective coordination of all State planning and service activities related to the field of aging

. to provide for ongoing monitoring and assessment and to conduct periodic evaluations of activities and projects in the field of aging, with special emphasis on the work of Area Agencies on Aging

. to assure, in cooperation with Area Agencies on Aging, the availability of information and referral sources in sufficient numbers so that all older persons will have reasonably convenient access to such sources by the end of fiscal year 1975.

To be eligible for grants under Title III, a State Agency on Aging, prior to the beginning of each fiscal year, is required to submit a State plan to the Commissioner on Aging for approval. The plan is to be developed by the State Agency designated by the Governor and then approved by the Governor prior to submission. Its specifications are set forth in regulations and guidelines promulgated by the Administration on Aging. Included in these specifications are the following:

. a statement of the measurable objectives, in priority order, established for the Title III program;

. a plan of action for discharging the responsibilities set forth earlier in the document;

. a plan for bringing about maximum possible coordination between the resources available under the Adult Social Services and Medical Care Titles of the Social Security Act and the operation of the programs under Title III;

- the division of the State into distinct planning and service areas;
- an identification of those planning and service areas in which Area Agencies on Aging will be designated and area plans developed during the fiscal year with priority consideration being given to those areas having significant concentrations or proportions of low income and minority older persons 60 years of age or older;
- an identification of the needs of the older persons within the State and the resources available to meet such needs.

b. Area Planning and Social Services

Prior to the enactment of the 1973 Amendments, State agencies funded service programs in accord with the differing needs of each community regarding aging-related services. More than 1700 projects were in operation during the year.

In-Home and Out-of-Home Services were developed and implemented to increase the capability of the elderly to maintain independent living and to prevent unnecessary institutionalization. Many elderly shut-ins were reached through this effort. These in-home and community services made it possible for elderly persons to maintain a sense of dignity and independence in their own communities. In-home services include homemaker services, home-health aides, escort services, friendly visiting, chore services, telephone reassurance, home repair and delivered meals.

Transportation is a major component of any service aimed at maintaining independent living, since it frequently means the difference between isolation and community involvement. Many of the community programs offered point-to-point transportation to make it possible for elderly persons to receive necessary care and participate in social and recreational activities. The community programs used buses, radio-equipped mini-buses, cars and other vehicles. These programs enabled the elderly to keep medical appointments, visit senior centers, participate in congregate meals, shop for groceries, attend religious and social activities and reach information centers for counseling and referral to service providers.

Health related services also helped older persons to continue to maintain independent living. Home visits by nurses under the direction of a physician, and by homemakers/home-health aides under the supervision of a registered nurse, provided nursing and personal care as well as light housekeeping. Other community health services were health education, geriatric screening and referral, and immunization programs. A number of programs gave particular attention to handicapped older persons, such as the blind or deaf.

Volunteers, many of whom were elderly themselves, assisted in providing such services as friendly visiting, telephone reassurance, teaching adult education courses to other older persons, and in the preparation and delivery of meals. Many were also involved in the planning of community activities and services for the elderly.

Even as these direct service programs were being carried out, planning was underway in 195 communities across the country in preparation for the new Title III program. Twelve-month planning grants, awarded at the end of 1972, had as their purpose the development of local readiness to initiate Area Agencies on Aging once new legislation and funding became available, and to lay the groundwork for the Title VII Nutrition program.

Title III of the Older Americans Act Amendments of 1973 establishes a new program that addresses the failure in most communities to systematically pool the resources and services that are available for older persons and to focus them in such a manner as to make a significant impact on the lives of those persons. The 1973 amendments provide the mandate for development of a network of agencies which are to be designated as Area Agencies on Aging across the country. The law provides that the State may designate a public or non-profit private agency or organization as an Area Agency on Aging. The State is required, however, to give preference to an established office on aging, where such exists.

In order to be eligible for grants under Title III, an Area Agency on Aging, prior to the beginning of a fiscal year, is required to submit a plan to the State Agency on Aging for approval. The specifications for the plan are set forth in regulations and policies established by the Administration on Aging. Included in these specifications are the following:

. a plan of action for discharging the responsibilities set forth in the legislation

. an operating plan that will give priority to those activities and services which will assist and benefit low income and minority older persons throughout the planning and service area, and will assure, to the extent feasible, that low income and minority individuals will be served at least in proportion to their relative numbers in the planning and service area

. a plan for bringing about maximum possible coordination between the resources available in the planning and service area under Title III and those available under the Adult Services and Medical Care Titles of the Social Security Act

. a plan for demonstrating to local governmental units how the priority established under General Revenue Sharing for social services for the poor or aged can be used in such a manner as to inaugurate new or strengthen existing services for older persons

. a plan for endeavoring to work out arrangements under which recipients of grants or contracts for nutrition projects mutually agree with the area agency that such nutrition projects shall be made a part of the area's coordinated and comprehensive service system for older persons.

The State is authorized to award funds to projects in planning and service areas where Area Agencies on Aging have not been designated. These projects must be of such nature, however, as to contribute to achieving the purposes set forth in Title III. These purposes include the concentration of resources in order to develop greater capacity to meet the needs of aging persons, and the development of comprehensive and coordinated service systems to serve older persons. High priority is placed on the use of funds to assure that older persons in each area have reasonably convenient access to information and referral services.

c. Areawide Model Project Program

The Areawide Model Project Program, which was authorized by the 1969 Amendments to the Older Americans Act, provided discretionary grants and contracts with State Agencies on Aging for the conduct of projects in selected geographic areas for the purpose of developing and testing innovative approaches in the planning and delivery of services to older persons.

The program was formally initiated at the end of Fiscal Year 1971 with the approval of the first nine Areawide Model Projects. Subsequently in FY 1972, twelve additional projects were funded. By the end of FY 1973 the twenty-one projects were in their first or second phase of program implementation. Of these projects, nine were operated directly by State Agencies, and twelve others have been sub-contracted by State agencies to public or private organizations in the designated areas.

In Fiscal Year 1973, the twenty-one Areawide Model Projects provided a variety of services in a coordinated fashion to meet the needs of the elderly in the selected geographical areas. Several service components common to most of the projects are information and referral services, transportation, food and nutrition services, health services and recreation activities. Other services provided included homemaker, home health care, handyman services, housing assistance, counseling and social services, education including consumer education, telephone reassurance, job placement, library services and legal assistance.

The Areawide Model Project concept became the prototype for the comprehensive and coordinated service systems for older persons, called for in the 1973 Amendments to the Older Americans Act. In view of this new strategy and higher level of funding authority provided in the new Amendments for Title III, the twenty-one Areawide Model projects have been incorporated into the Title III Area Planning Social Services network in FY 1974. It is expected that these twenty-one projects will provide the cornerstone for the establishment of comprehensive and coordinated programs for older persons in the newly designated planning and service areas.

d. Model Projects on Aging

The 1973 Older Americans Comprehensive Services Amendments to the Older Americans Act provide for a new Model Project program. The Commissioner is authorized to enter into contracts with or make grants to any public or nonprofit private agency or organization within a State, after consultation with the State Agency on Aging, to pay part or all of the cost of developing or operating Statewide, regional, metropolitan area, county, city or community model projects which will expand or improve social services or otherwise promote the well-being of older persons. Special consideration is given to projects which: (1) assist in meeting the special housing needs of older persons; (2) provide continuing education to the elderly; (3) provide pre-retirement education, information and related services to the elderly; and (4) provide services to assist in meeting the particular needs of the physically and mentally impaired older persons including special transportation and escort services, homemaker, home health and shopping services, and other services designed to assist such individuals in leading a more independent life.

Implementation of the Model Projects Program began in Fiscal Year 1974.

e. Nutrition Program (Title VII)

The Nutrition Program had its origin in 1968 with the appropriation of funds under Title IV of the Older Americans Act for a research and demonstration program to improve nutritional services for the elderly. These Title IV projects demonstrated the utility of congregate meals in providing older persons with opportunities for social interaction, facilitating the delivery of social services and improving nutrition for the elderly.

Under the provisions of Public Law 92-258, signed by the President on March 22, 1972, a national Nutrition Program for the Elderly was added to the Older Americans Act of 1965. This program is designed to meet the nutritional and socialization needs of individuals, aged sixty and older, who do not eat adequately because (1) they cannot afford to do so; (2) they lack the knowledge and/or skills to select and prepare nourishing and well-balanced meals; (3) they have limited mobility which may impair their capacity to shop and cook for themselves; and (4) they have feelings of rejection and loneliness which obliterate the incentive to prepare and eat a meal alone.

The purpose of this program is to provide older Americans, particularly those with incomes below the Bureau of Census poverty threshold, with low cost, nutritionally sound meals served largely in congregate settings, at strategically located centers.

These centers can be located in facilities such as: schools, churches, community centers, senior centers and other public or private non-profit institutions where other social and rehabilitation services can be obtained. Besides promoting better health among the older segment of the population through improved nutrition, such a program is aimed at reducing the isolation of old age and offering older Americans an opportunity to live their remaining years in dignity.

Each Title VII project must provide at least one hot meal per day, five or more days per week, and each meal must assure a minimum of one-third of the daily recommended dietary allowances as established by the Food and Nutrition Board of the National Academy of Sciences, National Research Council.

Supporting social services must be available and accessible to project participants as needed. These services include: outreach; transportation; personal escort; information and referral; health and welfare counseling; nutrition education; shopping assistance; and recreation activities incidental to the project. In order to assure that the maximum of hard-to-reach, isolated, low-income and minority elderly throughout the project area have the opportunity to participate in the project, the nutrition regulations require that an ongoing outreach service be provided from each congregate meal site. In addition, AoA has instituted an information and reporting system to assure that the low-income and minority elderly are given priority service. Supporting social services must be developed within thirty days after nutrition services have been initiated. To the maximum extent feasible, the project must make every effort to utilize existing social service resources provided by agencies such as health and mental health, public assistance, medicaid, social services, rehabilitation, education, economic opportunity, legal services, food and agriculture agencies and Title III community projects.

In view of the current pressing needs of some of the elderly for nutritional services, the Title VII regulations were amended to encourage the prompt initiation of nutrition projects and the start of their essential work of serving nutritious meals to the elderly. This amendment allows, under certain conditions, the postponement of the application of certain standards for nutrition projects in order to implement the program more rapidly.

In preparation for the implementation of this program, the Administration on Aging has completed plans for in-service training of Project Directors and major Site Managers of Nutrition Programs for the Elderly. The training program was pilot-tested at Corvallis, Oregon in cooperation with the School of Home Economics at Oregon State University. Also, five Regional training centers were established and are conducting the training. They are:

New England Center for Continuing Education - Durham, New Hampshire

Community Nutrition Institute - Washington, D.C.

North Texas State University - Denton, Texas

University of Nebraska at Omaha - Omaha, Nebraska

Oregon State University - Corvallis, Oregon

As a part of the training program, a "Guide to Effective Project Operations" was developed for use by agencies, organizations, and institutions which will be operating nutrition projects. This Guide is designed to convey basic information regarding major aspects of the Nutrition Program for the Elderly, and to provide technical assistance in program operations. A Nutrition Information System was developed, and training was provided to regional office and State agency staff regarding the installation and management of the system. Until the Nutrition Information System is fully operational, a weekly reporting system will provide a national summary of Title VII program progress.

FY'74 is the first year of operation for the Title VII program, since funds were not appropriated until July 1, 1973. As of January 4, 1974, State agencies had awarded $99,600,000 of the FY'73 Title VII allotments to fund 648 nutrition projects, 195 in rural settings and 453 in urban areas. Once these projects become fully operational they will serve 212,000 meals daily to older Americans. Seventy percent of the meals are being served to elderly persons with incomes below the Department of Commerce poverty threshold.

Technical assistance was provided to State Agencies and potential project grantees in each region to aid them in developing State plans and to prepare for implementation of the Nutrition Program. Forty-nine States, Puerto Rico, Guam, the Virgin Islands, and the District of Columbia submitted State plans which were approved. As of early 1974, American Samoa and the Trust Territories of the Pacific are not participating in the Nutrition Program.

2. INTER-AGENCY COORDINATION

Important developments in the area of inter-agency coordination include the creation of the Interdepartmental Working Group of the Cabinet-level Domestic Council Committee on Aging, of which the Commissioner on Aging is chairman, and the Committees on Aging of the Federal Regional Councils. The objective of these new Inter-Agency authorities is to facilitate research, planning and program initiatives across organizational boundaries to accelerate the development of the comprehensive and coordinated system of services called for in the 1973 Amendments to the Older Americans Act.

The 1973 Amendments direct AoA to "coordinate, and assist in, the planning and development by public (including Federal, State and local agencies) and non-profit private organizations of programs for older persons, with a view to the establishment of a nationwide network of comprehensive, coordinated services and opportunities for such persons." The amendments also strongly emphasize coordination of Federal resources and services at the State and sub-State levels by State and Area Agencies on Aging to improve the social service system for older persons.

In addition to the new Inter-Agency responsibilities mandated to AoA by the 1973 Amendments, the Administration on Aging is continuing those inter-agency agreements which were initiated in FY 1973. Within HEW, joint projects continue with the Health Services and Mental Health Administration (now the Health Services Administration) Office of Education, and Social Security Administration. Cooperative activities are also in progress with Housing and Urban Development, Transportation and the Veterans Administration.

a. AoA-HSMHA Cooperation

Under the AoA-HSMHA agreement, joint efforts were focused on cooperative funding of research and demonstration grants, health technical assistance by HSMHA Regional offices to areawide model projects funded by AoA, AoA assistance with the nursing home ombudsman program, planning for long-term care and alternatives to institutionalization, and development of a HSMHA objective calling for joint action in health planning.

In several regions the HSMHA and AoA regional staffs collaborated on the development of health components in areawide model projects, and established other informal working agreements. AoA and the Mental Health Administration also worked with the newly created Division on Aging of the National Association of State Mental Health Directors to try to effect cooperation with State agencies on aging.

The Administration on Aging continued to work with the six nursing home ombudsman programs, five of which are funded by HSMHA and one jointly by HSMHA and AoA, to review progress, promote State agency on aging cooperation, and confer with the ombudsman staffs regarding program development. AoA also worked with HSMHA, the ombudsmen, and the HEW office of Mental Retardation Coordination to point up problems of mentally retarded patients in nursing homes as reported by the ombudsmen.

In FY 1973, four new research and demonstration projects were added to the seven previously funded under the AoA-HSMHA joint funding agreement. Two of the new projects relate to mental health of the elderly and the other two are concerned with improved geriatric and nursing home care.

b. AoA-Office of Education Cooperation

During the year the Administration on Aging worked with two bureaus in the Office of Education on cooperative programs: the Bureau of Libraries and Learning Resources and the Bureau of Adult Vocational and Technical Education.

AoA cooperated with the Bureau of Libraries and Learning Resources on a demonstration project utilizing the branch libraries in five metropolitan communities as information and referral centers by providing expertise from the AoA Statewide information and referral project in Wisconsin. An interchange of experience and findings of benefit to both the Bureau and AoA has continued.

With the Bureau of Adult, Vocational and Technical Education, AoA explored the use of the network of teachers of home economics as a resource in the nutrition education program mandated under Title VII of the Older Americans Act. This resulted in a joint AoA-BAVTE memorandum to State Agencies on Aging and State Supervisors of Home Economics Education urging joint efforts "to promote optimal nutritional status among elder citizens through cooperative programming, literature and all other appropriate means." AoA also fostered consideration within the Bureau's Division of Adult Education, which resulted in the agreement that older adults, age 45 and above, constitute a group whose needs should be more adequately addressed in Special Projects funded under the Adult Education Act. Such an agreement is reflected in priorities for FY 1974 as published in the Federal Register.

c. AoA-Office of Consumer Affairs Cooperation

Consumer education for older persons is one of the supportive services provided by the Title VII nutrition program. Following the President's 1972 message to the Congress on action for older Americans, which included a directive on the development of consumer education programs for the elderly, the Administration on Aging and the Office of Consumer Affairs cooperated in responding. The Office of Consumer Affairs developed a pamphlet entitled, "An Approach to Consumer Education for Adults" with a section on the Elderly Consumer. That Office in conjunction with the Administration on Aging and the HEW Office of Consumer Affairs met with the Federal Executive Board Consumer Committees relative to programs for elderly consumers. The Federal Executive Boards, located in 25 major cities and made up of heads of all Federal agencies in the city, are working on plans for cooperative programs aimed at older consumers in conjunction with area agencies on aging.

d. AoA-Social Security Administration Cooperation

AoA continued to work with the Social Security Administration on information and referral services. SSA had been given responsibility for providing information on all Federal aging programs by the President during the White House Conference on Aging. AoA also worked with Social Security on distribution to State Agencies on Aging of informational materials concerning the Supplemental Security Income program. A special project called

"SSI Alert" has been developed and is being implemented by AoA and SSA to alert potentially eligible older people to the SSI benefits and options. Also involved are the American National Red Cross and six major national organizations of older persons.

e. AoA-HUD Cooperation

AoA and the Department of Housing and Urban Development continued to collaborate at the Federal and Regional levels. Efforts were also continued by AoA, HUD and the Law Enforcement Assistance Agency on security for the elderly in housing projects. Meetings were held with the American Association of Retired Persons on security following the AARP addition of staff to work on security for the elderly. This topic was also chosen as one of the priorities by the Region II, Mid-Atlantic Federal Regional Council Human Resources Committee's Task Force on Problems of the Elderly. Also, during the year, AoA and HUD continued to meet on possible joint funding of research and demonstration grants. AoA in cooperation with HUD made a training fund grant to the National Center for Housing Management for the training of managers of housing for the elderly. Three groups of managers were trained during the year.

f. AoA-DoT Cooperation

The Administration on Aging and the Department of Transportation continued to work together on the transportation problems of the elderly. DoT appointed a coordinator for problems of the elderly and handicapped. Together, AoA, DoT, and the Connecticut Department of Transportation funded a model project to test a service to improve access to and use of health and social services. By agreement between DoT and AoA, AoA funded a grant to the Institute of Public Administration to analyze policies and research needed for further demonstrations of transportation services for aging.

g. AoA-VA Cooperation

The Administration on Aging and the Veterans Administration continued the exploration of ways in which they could cooperatively assist older veterans and older persons generally. A plan was developed by AoA and VA central office staffs to try to involve VA facilities staffs in the planning and development of services in the Areawide Model Projects. To test the plan, visits were made to the Tucson, Arizona, and Syracuse, N.Y., Areawide Model Projects where joint meetings of VA and Areawide Model Project staffs were held and cooperative efforts initiated. In Syracuse, the VA also began the examination of possible joint research between VA and the AoA gerontology centers. One further joint visit is planned in preparation for possible VA instructions to facility staffs calling for cooperation with area agencies on aging. Both the Tucson and Syracuse projects showed that the services were benefiting substantial numbers of veterans in the communities and helping prevent institutionalization.

h. Retirement Planning Programs

The Administration on Aging continued to assist various Federal departments and agencies in the development and presentation of retirement planning programs. AoA provided background materials to departments and agencies for inclusion in kits given to participants in retirement planning programs. AoA also worked with the General Accounting Office on a proposed study and monitoring of retirement planning programs offered to Federal employees.

1. AoA-Interfaith Cooperation

AoA has provided continued assistance to The National Interfaith Coalition on Aging, which was organized as an outgrowth of the White House Conference on Aging Section on Spiritual Well-Being and of preliminary work with the denominations by AoA. During 1973, the Coalition began the establishment of an operating base and budget for staff. It also set up a special research division to manage the research into services to the elderly by churches under a grant of Title IV research funds made by the Administration on Aging. At its annual meeting held in Washington during May - Senior Citizens Month - the Coalition leaders consulted with the Commissioner and staff on church participation in the Title VII nutrition program and in area agencies.

The primary objectives of the Coalition are:

(1) To develop an awareness of and to vitalize the role of the church and synagogue with respect to their responsibilities in improving the quality of life for the aging.

(2) To identify and give priority to those programs and services for the aging which best may be implemented through the resources of the nation's religious sector.

(3) To stimulate cooperative and coordinated action between the nation's religious sector and national secular private and public organizations and agencies whose programs and services relate to the welfare and dignity of aging people.

(4) To encourage the aging to continue giving to society from the wealth of their experiences and to remain active participants in community life.

AoA has also worked with the denominational members of the Coalition as opportunities arose, such as with the Task Force on Voluntary Service, Presbyterian Church-U.S., on older persons and voluntary service. Since the Coalition began its work, a Division of Gerontology of the Union of American Hebrew Congregations has come into being.

3. RESEARCH AND DEMONSTRATIONS

The Administration on Aging's research and demonstration program supports projects which add to existing knowledge in a wide variety of areas that are critical to the development and improvement of aging programs. The primary source of funding for R&D projects in aging is Title IV of the Older Americans Act. Prior to AoA's move from the Social and Rehabilitation Service during April 1973, funding support was also received from Sections 1110 and 1115 of the Social Security Act.

Title IV of the Older Americans Act provided grants for approximately 25 new projects for the study of problems of elderly people and the delivery of services to them during fiscal year 1973. The major priority guiding the selection of studies or demonstrations of applied knowledge was returning or maintaining vulnerable elderly in their own homes or appropriate community settings. For example, building on substantial research in progress, the

Office of Elder Affairs in Boston began a demonstration on community-based home care programs of coordinated health, social, and other support services. These home services draw on the same source of funds now being used to pay for institutional care (Medicaid), and it is hypothesized that a more desirable, more efficient and less costly option can be provided for elderly who are currently being placed in nursing homes and other institutional settings. This project is also supported by the National Center for Health Services Research and Demonstrations of the Health Services and Mental Health Administration and by a Medical Services Administration waiver to permit use of Medicaid funds.

Four projects are studying the problem of day care services for elderly people who without such services would be institutionalized or those who could be returned to community living if such services were available. The program of the Chinatown-North Beach Health Care Planning and Development Corporation in San Francisco is directed at three ethnic minority groups--Chinese, Filipino, and Italian. This project is supported by funds authorized by Title IV, Older Americans Act, and Section 1110, Social Security Act. The Levindale Hebrew Geriatric Center and Hospital in Baltimore seeks to produce findings which would lead to changes in Medicare-Medicaid legislation which underwrite health care predominately within an institutional setting. The project sponsored by the Burke Rehabilitation Center in White Plains, New York, is focused on day care services within the context of total community services and linked to an information and referral system; it is also supported by Title IV and Section 1110 funds. Montefiore Hospital in New York City is evaluating day care services with funds from Section 1110.

Other parameters of the problems of alternatives to institutional care are being explored in the following ways. The Colorado Department of Institutions, Denver, is testing the feasibility of specialized boarding homes for elderly persons who have had or continue to have mental problems. This approach holds promise for a lower cost and more effective alternative to nursing homes, mental hospitals, or in-patient psychiatric hospitalization. It is jointly supported by Title IV and HSMHA through the National Center for Health R&D. The Family Service Association of America, with support from Title IV and NIMH, is undertaking to strengthen the quality and expand the scope of programs for the aging in local family services agencies, with the overriding objective of enhancing programs which will enable the elderly to remain in their own homes. A manual for training homemakers in home care for the elderly is being developed by the National Council for Homemakers Service, while the National Center for Voluntary Action is developing program guides for voluntary organization use in establishing home service programs for the elderly. In the religious sector, the National Interfaith Coalition on Aging, Athens, Georgia, is examining programs for the aging and information systems about services for the elderly, with the goal of improving correlation of public and private efforts for the older adult population.

A number of Title IV projects are directed at filling existing knowledge gaps and at examining neglected problems in a variety of areas. All of these areas have significant implications for the vulnerable, institutionalized, and minority elderly. The potential for translating electronic and technological advances into care for the elderly is being examined by the Illinois Institute of Technology, while Inter-Study of the American Rehabilitation Foundation is investigating the potential for use of cable TV in an information and referral system.

The Massachusetts Secretary of Elder Affairs, with support from Title IV and HSMHA, is experimenting with a Nursing Home Ombudsman program to improve the quality of care received by patients within nursing homes. Montefiore Hospital in New York City is evaluating the effectiveness of brief psychotherapy to the bereaved aged, while the New York State Department of Mental Hygiene is developing refined measures for the detection of psychopathological conditions in the elderly and identifying implications for treatment. At the University of Chicago, a simple psychological instrument that is valid and reliable for measuring personality characteristics in middle-aged and older people is being developed. In the area of minority concerns, the Montana United Indian Association is studying the nature, type, and extent of problems and needs common to elderly urban Indians. The University of Pennsylvania is assessing the impact of the 1972 flood damage in Wilkes-Barre on elderly people, and seeking to determine the responsiveness of service agencies to crisis. With Section 1115 funds, the WCGH Health Care Program for the Inkster Community, Michigan, is providing outreach to elderly public assistance recipients for medical services.

Other activities in process include a strategic exploration of national policies affecting the elderly and construction of data-based predictions of the future, given present policies or alternative policies. This work is being done by the Stanford Research Institute. The Oregon State Legislative Interim Committee on the Aging is undertaking to develop a legislative strategy to meet the service needs of the elderly which are not currently being met by existing programs but which were identified by the White House Conference on Aging.

The University of Southern California Gerontology Center is organizing, evaluating, and analyzing research data, concepts, theories, and issues on the biological, psychological, and social aspects of aging for publication in three volumes of Handbooks in Gerontology. These Handbooks will organize available information on aging for purposes of teaching, research, policy development, and program planning. The Gerontological Society began work on state-of-the-art papers on key social policy needs, possible alternative solutions, and the kinds of research, development, and information that would be useful in making policy decisions responsive to such needs and issues.

Important work begun in earlier periods was continued in 1973. In particular, social service and nutrition projects in Illinois and Florida made progress. The Florida project is co-sponsored by Title IV and Section 1115. Title IV continued to support a State-wide information and referral demonstrations in Wisconsin, and several transportation and mobility demonstrations. Support of research on transportation for the elderly and handicapped in the Naugatuck Valley of Connecticut was continued. A study of the supply and demand of jobs suitable for older workers is being carried out by the Human Resources Center, Albertson, New York, under Section 4A of the Vocational Rehabilitation Act.

Continuing demonstration projects funded under Section 1115 for elderly recipients of public welfare included housing assistance in Eastern Kentucky and Georgia, consumer affairs assistance in Georgia and Michigan, delivery and coordination of services in Florida and New Jersey, homemaker and home management services in Washington, Virginia, Montana, Utah, Florida, and Tennessee. Other 1115 projects involve aged welfare recipients in pre-paid health insurance plans and health maintenance organizations. Several studies of intermediate housing as an alternative to institutional care, begun in 1971, made considerable progress in 1973.

In keeping with the substantial new responsibilities accorded to the Administration on Aging by the 1973 Amendments to the Older Americans Act, high priority for the use of funds made available to the AoA for research in aging during FY 1974 is being placed on projects that are designed to help those persons at the Regional, State and Area levels who are charged with the implementation of Title III. Of priority interest is research directed to the solution of problems which are barriers to the effective development of coordinated and comprehensive service systems for older persons at the State and sub-State levels.

4. TRAINING

Prior to the 1973 Amendments to the Older Americans Act, Title V of the now expired legislation provided for a training grant program which, from its inception in 1966, had as its objective the recruitment and preparation of manpower required for expanding the programs, facilities, and services called for in the Older Americans Act of 1965. Specific manpower activities included career education, short-term training, development of training materials, conferences, and studies to assess needs in the field. In 1973 the following manpower activities were in progress.

a. Career Education in Aging

Most of the career training programs in aging were initially established at the graduate levels. In 1973 support was provided for training at the baccalaureate, master's and doctoral levels.

The objectives of the career development program were to prepare practitioners for State and Federal program planning and administration, community development and coordination, management and administration of retirement housing and homes for the aged, senior center direction, teaching and research; and for serving older people through adult education, architectural design, counseling, law, library service, recreation, and other relevant fields.

Each career-oriented training program included an intensive practicum of from three to nine months. Students and graduates have demonstrated to program agencies the value of personnel who have systematic knowledge of the aging processes and of older people. An evaluation study commissioned by AoA in FY 1973 showed that most graduates of the training programs have readily found employment in the field.

Administration on Aging-supported career training programs have from their inception sought to recruit students from all minority groups. In FY 1973 eight continuation awards were made to minority institutions or others with programs specifically focused on minority students. Approximately 22% of the students enrolled in career programs during 1973 were from minority groups.

One award, made in FY 1972, supported a conference in 1973 for minority faculty persons entering the field of aging. The preparation of a text about elderly blacks, supported by a grant in FY 1972, is scheduled for completion by the end of FY 1974.

In FY 1973 AoA supported career training programs in 47 institutions. These included 34 programs which offered interdisciplinary education for one or more of the priority areas listed above, with specialization in gerontology. In addition, 13 awards were made to schools of social work to prepare students for community development to meet the needs of the older population.

In the 47 programs, approximately 400 students will receive traineeships from FY 1973 funds for education in the 1973-74 academic year.

b. Multidisciplinary Centers in Gerontology

The 1973 Amendments add a new provision, Title IV, Part C, for the support of multidisciplinary centers on aging. Funds for support of such centers however, have not been requested. Under previous authority, the Administration on Aging has provided funds to at least one major institution within each Region toward the support of a multidisciplinary gerontological center. The underlying AoA objective grew out of the recognition that several such centers were making significant contributions to the emergence of aging programs, nationally and within the geographic areas they served. In each instance, the institution was engaged in gerontological research, in providing educational preparation for several career areas in aging, in conducting evaluative studies, conferences and short-term training, and in offering technical assistance and consultative services.

c. Short-Term Training

AoA has in previous years supported a number of short-term training programs. These have offered training ranging in duration from a few days to 14 weeks. They have provided intensive education in gerontology and in a variety of skills to several hundred persons recruited from all parts of the country.

Support for short-term training was expanded in 1973. Major emphasis was placed on the development of curricula, training materials, and training specifically designed to help prepare State and Area Agency on Aging and nutrition project personnel for effective implementation of the Older Americans Comprehensive Services Amendments of 1973. Grants for this purpose were made to one institution in each Region, including eight multidisciplinary centers in gerontology. Training programs of from three to ten days will utilize AoA-developed curricula to train an estimated 3,000 persons by the end of FY 1974.

d. Other Special Projects

Three projects with great potential significance which were initially funded in FY 1972 received supplemental awards in 1973. The grant to the American Association of Community and Junior Colleges enabled the Association to: (1) compile an inventory of the extent of involvement of its 1,100 member colleges in the field of aging; (2) develop curriculum models for preparing semiprofessional personnel for the field; and (3) bring college personnel together with State and local aging agency personnel to develop mechanisms for collaboration.

A supplemental award to the National Center for Housing Management covered the costs of including specialized content on aging in training managers of housing for the elderly. A curriculum being developed under this award is expected to be available for nationwide use by community and junior colleges and other adult education facilities.

The other supplemental award was made to the International Center for Social Gerontology in partial support for an international symposium on Housing and Environmental Design for Older Adults. The symposium was held in Washington, D.C., in December, 1973.

5. NATIONAL CLEARINGHOUSE ON AGING

A major event of 1973 was the establishment of a National Clearinghouse on Aging within the Administration on Aging in response to a directive set forth in Title II of the Older Americans Comprehensive Services Amendments of 1973. The Clearinghouse is charged with (a) collecting, analyzing, and disseminating information about older people and their needs, (b) providing information to agencies and organizations with respect to programs for older persons, (c) encouraging the establishment of State and Area information centers and referral services, (d) carrying out a program of consumer education for older people, and (e) stimulating other agencies to prepare and disseminate information for the field of aging.

The Clearinghouse was organized with four units: Data Analysis and Dissemination, Public Information, Public Inquiries and Publications Distribution, and Information and Referral. A staffing plan was developed within the limits of AoA's resources and descriptions were prepared for several new positions required by expanding activities.

a. Data Analysis and Dissemination

During 1973, AoA continued to provide a variety of quantitative information about older people and programs for them, to planners, program administrators, researchers, and others within government agencies at all levels and to personnel of non-government organizations. The activities are described as follows:

(1) Development of Resources - Cooperative arrangements with all data collecting and tabulating agencies were continued and reinforced to promote the exploitation and distribution of data and findings concerning the older population, especially in view of the flow of data from the 1970 census enumeration.

During 1973, an effort was made to support the thrust of the Older Americans Comprehensive Services Amendments of 1973 which provide financial assistance to sub-State units planning for comprehensive and coordinated services to older persons. In an effort to help provide "small area" data as an essential input to the State and sub-State planning process, the Administration on Aging has been active in determining what the Census Bureau publishes, what it will prepare under contract, and what it sells in the form of computer (magnetic) tapes that carry partially summarized data. This information and related information on other sources and on the organized census users tape processing centers across the country have been made available to the State agencies on aging.

In addition, considering the savings and efficiency of a large scale and centralized approach to data processing, AoA has been negotiating with the Office of Economic Opportunity and the Department of Housing and Urban Development with a view of designing "small area" tabulations (primarily counties) that will serve a larger number of purposes.

The Older Americans Comprehensive Services Amendments of 1973 established age 60 and over as the base for the State allotment formulas, rather than the former 65 and over. Data on the characteristics of the 60-64 age group are very scarce. What data are available tend to indicate that the individuals aged 60-64 are different in important aspects from those aged 65+. For example:

	65+	60-64
Men in labor force (percent)	25	74
Women in labor force (percent)	10	36
Persons (millions, mid-1970)	19.3	8.4
Percent in families	69.8	81.6
Percent living alone or with nonrelatives	30.2	18.4
Percent who are spouses	20.4	32.3
Percent female relatives of head but not wife	9.0	3.8
Number living in "poor" households (millions)	4.7	1.1

In addition to discussions with the Census Bureau concerning future tabulations that permit breaking out the 60-64 age group for analysis of both the 65+ and the 60+ totals, special negotiations were completed on:

(1) Reconciliation of the differences in the reported numbers of persons 65+ in the various 1970 census reports because of sampling differences.

(2) Correction of errors in OEO computer tabulations of Census Bureau tapes that gave us detailed data on "the aged poor" by State, by color, and by urban-rural residence based on 1969 income as reported in the 1970 census enumeration.

(3) Reconciliation of the differences between estimates of the aged poor in 1969 as derived from the 1970 census enumeration and from the March 1970 Current Population Survey, resulting primarily from sampling and some definition differences.

(4) Special arrangement whereby the Census Bureau will supply to AoA in December of each year estimates of the 60+ and 65+ populations in each State as of July 1 of that calendar year for more accurate computation of State allotments under the Older Americans Act and for general data use.

(5) Advance data on income and poverty in 1971 and 1972 for analytical purposes and a special summary of income distributions for the total under-65 group to facilitate comparisons.

Negotiations were conducted on:

(1) Developing with HUD a conceptual basis to arrive at a measurable definition of "need" for housing for older persons. As a first step, tentative agreement was reached on a working definition for future testing of the concept "need for Federal assistance" in terms of the availability of housing in the community at a rental not exceeding 25% of the income of the older adults.

(2) Amendment of a new annual survey of housing to permit tabulation of data for older persons and identification of areas of concern or conditions that are most important to older persons.

(3) Joint agreement with the Housing Division of the Census Bureau which led to publication of a volume of tabulations on "Senior Citizen Housing" which will include cross-tabulations with data from the Census of population.

(4) Joint planning for an analytical and resource publication which was distributed at the International Symposium on Housing and Environmental Design for Older Adults in December 1973 in Washington, D.C., conducted by the International Center for Social Gerontology.

At a series of meetings with staff members of the Senate Special Committee on Aging and of the National Council on the Aging, an informal procedure was developed for exchange of information and publications in order to avoid duplication of effort and waste of scarce technical staff capacity.

Negotiations continued with two agencies in the Department of Justice concerning the collection, tabulation, and reporting of "age of victim" in crime reporting.

(2) General Dissemination - In addition to contributing statistical and analytical materials for use in a wide variety of popular and technical publication, AoA maintains a statistical - general title of "Facts and Figures on Older Americans". Three new analyses were published during 1973:

No. 6 State Trends, 1950-1970
No. 7 Income and Poverty in 1972 - Advance Report
No. 8 Poverty by State and Ethnic Group (1969).

A revision of a 1966 pamphlet of charts and accompanying analyses, entitled "New Facts About Older Americans" was printed.

During the year, an informal statistical memorandum series was developed to supplement the more formal "Facts and Figures on Older Americans" series. Subjects covered through the end of 1973 included:

(1) Older Persons of Spanish Origin
(2) BLS Retired Couple Budget
(3) Authorizations in HR 15657 (92nd Congress bill to amend the Older Americans Act, etc.)
(4) Utilization of Short-Stay (General Hospitals), 1969
(5) Rehabilitation of Older Persons
(6) New Commercial Service - Selecting a Place to Retire
(7) Older Persons in the Voting Age Population
(8) Conversion from 65+ to 60+ Age Groupings
(9) Newspaper Report on Increasing Life Span
(10) BLS Retired Couple Budget (Supplement #2)
(11) Cumulative Impact of Inflation
(12) Unofficial Estimates of State Older Populations
(13) Organization of the Senate Special Committee
(14) Newspaper Report on "Senility"
(15) Religious Organization Position on "Euthanasia"
(16) Alcoholism Among Older Persons
(17) Surgery in Episodes in Short-Stay Hospitals
(18) Summary and Legislative History of 1972 Social Security Amendments
(19) Definition and Use of Standard Metropolitan Statistical Area (SMSA)
(20) Health Status and Care of the Older Population in 1971
(21) State Population Aged 60+ and 65+, 1971 and 1972
(22) Marriages of Older Persons in 1968
(23) Enrollment of Older Persons in Independent Private Health Insurance Plans, 1971
(24) Ethnic (National) Origin of the Population
(25) Projections of the Population to the Year 2000
(26) BLS Retired Couples Budget, Autumn 1972, Supplement #3
(27) Centenarians Receiving Social Security Cash Benefits Payments, June 1973

(3) Services to State Agencies - During 1973, a flow of information to the State agencies on aging transmitted especially useful statistical or analytical materials and resource materials (on a State basis) providing National trend data to assist in the preparation of State estimates.

Maintenance of "State Data Books" in the State agencies was continued. The tables in the Data Books were analyzed for the specific source of the data. A cross-reference file was established so that the arrival of publications containing necessary data automatically triggers the preparation of revised or new tables. Additional search and follow-up efforts permitted preparation of a large number of replacement pages containing newer data for duplication and transmittal to the State agencies.

(4) Special Technical Assistance - AoA responded to hundreds of requests for data, for technical assistance, and for consultation in related areas of research, analysis, planning, studies, resources for training and institute activities, and special analyses or presentations. Requests came from public agencies at the Federal, State, and local level, and from private organizations concerned with the elderly.

A large number of requests was received from House and Senate legislative committees considering the 1973 Older Americans Comprehensive Services Amendments. Included were analyses of definitions and specific provisions contained in the new legislation, including the concept of "area" and age concentration in cities and counties, etc., and the purposes and impacts of State allotment formulas.

A considerable amount of data and technical assistance was provided to the Senate Special Committee on Aging and the Task Force on Aging of the House Republican Conference.

Other special staff services were provided during 1973 as indicated:

. Involvement with other Federal agencies in developing preliminary data bases in preparation for implementation of the new National Clearinghouse on Aging, established by Title II of the 1973 Older Americans Act Amendments.

. Evaluation of experimental social indicators studies in regard to their prospective utility for aging-related service programs.

. Assistance to other Federal agencies in preparing responses to the Domestic Council request for financial commitments for aging programs in relation to the FY 1973 survey of Federal Outlays in Aging.

. Active participation in and presentation of data for a number of conferences.

(1) Workshop of State Public Welfare Research and Statistics Officials.

(2) Career Development for Professionals in Mental Health of the Aged.

(3) First Annual Fordham University (N.Y.C.) Institute on Gerontology.

(4) Duke University Conference on Successful Aging.

(5) Expansion Activities - Almost immediately following the enactment of the 1973 amendments to the Older Americans Act, AoA initiated actions looking toward the expansion of its information and data collection and dissemination responsibilities as envisioned in the legislation.

A contract was executed with an outside management agency to query users and potential users about their data needs, to begin the collection and indexing of such data, to design a system for maintaining an information and data book, and for storage, retrieval, and dissemination. Launching of the expanded operation within AoA is scheduled for early 1974. Initially, the focus will be on providing data for AoA's staff charged with planning, evaluation, and program responsibility. The data to be collected is initially limited to the low-income and impaired, non-institutionalized elderly, two target groups defined in AoA objectives. Subsequently, the data program will be expanded to cover the entire older population and to provide more detailed data to State and Area agencies and to other organizations in the field.

b. Information

The combined responsibilities of preparing for the establishment of the National Clearinghouse on Aging and responding to a vastly increased number of inquiries from Congress, public and private agencies, and the general public regarding the new Titles III and VII programs, heavily engaged AoA in information activities throughout 1973.

(1) Senior Citizens Month - "Older Americans in Action" was selected as the theme for Senior Citizens Month, May 1973. AoA prepared and distributed 75 thousand large and 75 thousand small posters based on this theme, and distributed 75 thousand copies of a Presidential proclamation designating May as Senior Citizens Month. For the second time since May was first named Senior Citizen Month nationally in 1963, a television spot was prepared, distributed nationally, and widely used. It contained the name and address of each agency on aging in each State where it was distributed and used.

(2) Film on Aging - During the year, a 16 mm., color and sound film-- "Don't Stop the Music" -- was produced, largely from film segments remaining from the films made for the White House Conference on Aging multi-media presentation. "Don't Stop the Music" challenges the negative stereotypes of older people by showing them in effective and creative action.

Prints of the film will be available from Regional Offices, State Agencies on Aging, and the National Audiovisual Center of the General Services Administration in Washington, D.C.

(3) Major Publications - Nine issues of the AoA magazine Aging were published in 1973. Early in the year more than 200,000 copies of a booklet, To Find the Way to Services in Your Community were prepared and distributed in response to inquiries evoked by a public service TV announcement. A Spanish language version was printed.

The Guide to Effective Project Operations: The Nutrition Program for the Elderly was also translated into Spanish, printed, and distributed to States requesting it for the use of project personnel.

The Government of the Netherlands requested and was granted permission to reprint in Dutch the AoA publication The Fitness Challenge in the Later Years.

In addition to fact sheets on the titles of the Older Americans Comprehensive Services Amendments of 1973, other publications produced in 1973 included:

Partnership for Older Americans, giving examples of programs in which Federal, State, local agencies, national organizations, or older people themselves are cooperating to help older people.

New Facts About Older Americans, an 8-page statistical folder.

Project Helping Wheels, a report on an AoA research and demonstration project in Raleigh, North Carolina, with "how-to" suggestions.

A Selected Annotated Bibliography of Nutrition and Aging.

Basic Concepts of Aging (Revised).

Reaching Out and The Resource File, the first two of a series of manuals on information and referral.

Work Study Program in Social Gerontology, a revision of A Plan to Span.

AoA Catalog of Films on Aging.

Fact Sheet: Alternatives to Institutionalization

Fact Sheet: Centenarians Receiving Cash Social Security Benefits, June 1973

Fact Sheet: Employment and Volunteer Opportunities for Older People (revised).

In addition, information assistance was provided to a number of media contacts, including several with television stations and others with the following associations or publications: United Press International, the National Observer, Journal of Home Economics, Reader's Digest, Washington Post, Cleveland Plain Dealer, Baltimore Sun, McGraw Hill, Local Government Funding Report, Food Management, Journal of Psychiatry, Woman's Day, Wall Street Journal, National Restaurant News, Philadelphia Inquirer, Democrat Chronical, and Christian Science Monitor.

c. Public Inquiries and Publications Distribution

Forerunners of the Administration on Aging began to respond to requests for information and program guidance in the emerging field of aging almost a quarter of a century ago. Today, AoA receives scores of letters, telephone calls, and office visits weekly from persons seeking information about program operations, sources of support, publications, services available for older persons, and guidance in developing services for them. Inquiries directly related to AoA-supported programs are handled by the program units, all others by the Clearinghouse. Something on the order of 2,600 response letters were prepared by the public inquiries staff during 1973 and approximately 250,000 publications were mailed to individuals and organizations who requested them.

d. Information and Referral

A requirement of the 1973 amendments is that all older Americans must have reasonably convenient access to information and referral to needed services. A new AoA staff member began to study existing I and R services and to assemble information that will be useful in providing technical assistance to State and Area Agencies. Valuable knowledge was being drawn during 1973 from an AoA-supported network demonstration project operated in 14 communities by the Wisconsin Division on Aging with guidance from Inter-Study of Minneapolis. During the year, AoA issued 9 publications on different aspects of I and R services and distributed them to State Agencies on Aging. Several jurisdictions were reported to be experimenting with or tooling up for Statewide programs.

6. THE FEDERAL COUNCIL ON THE AGING

Another major development resulting from the signing of the 1973 Amendments to the Older Americans Act is the new Federal Council on the Aging.

The 1965 Act established an Advisory Committee on Older Americans to advise the Secretary of Health, Education, and Welfare. The 1973 Amendments withdrew statutory authorization of that Committee, but established a Presidentially appointed Federal Council on the Aging with significantly broader responsibilities. Council membership consists of representatives of older Americans, national organizations with an interest in aging, business, labor, and the general public.

The Federal Council on the Aging has a clear mandate to serve as the national focal point for all advocacy efforts on behalf of the elderly and to channel and direct these activities to have maximum impact on the aging-related policies and programs of the Federal government. In such capacity, the Federal Council on the Aging performs the following functions:

(1) advises and assists the President on matters relating to the special needs of older Americans;

(2) provides and conducts public forums and hearings, conferences, workshops and other meetings to obtain information, and to discuss and publicize the problems and needs of the aging;

(3) reviews and evaluates Federal policies, programs and activities regarding the aging for the purpose of appraising their value and their impact on the lives of older Americans;

(4) acts as a spokesman on behalf of the elderly by making recommendations to the President, to the Secretary and the Commissioner, and to the Congress with respect to Federal policies, programs and activities regarding the aging;

(5) informs the public about the problems and needs of the aging, working through the National Clearinghouse on Aging, by collecting and disseminating information, conducting or commissioning studies, and by issuing publications and reports;

(6) assists the Commissioner in making annual appraisals of manpower needs in the field of aging.

7. OFFICE OF PLANNING AND EVALUATION

AoA's Office of Planning and Evaluation (OPE) was established during 1973. Its establishment brought increased internal emphasis on the functions explicit in the Office title, and combined in a single organizational unit, primary agency responsibility for the functions of planning and evaluation and legislative and policy analysis.

Among its specific responsibilities, the Office:

(a) serves as the focal point in the Administration on Aging for forward (5-year) planning, policy analysis, and evaluation.

(b) compiles the Administration on Aging foward plan, with appropriate input from other AoA units.

(c) conducts policy analyses of a wide range of basic program issues affecting the Administration on Aging or programs for the aging.

(d) prepares annual AoA reports to the President and the Congress.

(e) develops Administration on Aging legislative proposals.

(f) identifies policy issues in proposed legislation affecting the elderly.

(g) develops reports on pending legislation as requested by the Department.

(h) obtains information on State legislation on aging, and periodically publishes such information, as well as information for the States on new legislation.

(i) works with States and Regional offices to develop model State legislation.

(j) develops and implements an annual evaluation plan for the Administration on Aging.

(k) prepares program evaluation guidelines for use by State and area agencies on aging.

(l) provides secretariat and principal analytical support services to the Federal Council on the Aging.

(m) provides principal staff support for the Federal Interdepartmental Working Group of the Cabinet-level Domestic Council Committee on Aging.

(n) monitors follow through by Federal agencies on implementation of commitments made in the Administration's response to the recommendations of the White House Conference on Aging and the Post White House Conference Board.

In the following is a more detailed summary, by functional area, of the major OPE initiatives during 1973.

a. Planning

During 1973, OPE's major planning activities included the development of long-range planning guidance on AoA activity between FY 1975 and FY 1980. Preliminary plans were offered to guide AoA in carrying out the objectives of the Older Americans Comprehensive Services Amendments of 1973 and enhancing the status of the agency as the Federal focal point on aging.

Planning staff has also participated in the on-going review of Title IV, Research and Demonstration grants, relative to their implications for short and long-term planning in aging.

b. Legislative and Policy Analysis

Throughout the year, there has been an on-going, in-house analysis of major issues related to the conduct of programs under Titles III, IV, and VII of the Older Americans Act, as amended. Included in this on-going analysis has been review of current AoA program implications for the 1974 and 1975 legislative cycles. Also included have been analyses of the implications of current Departmental initiatives, including decentralization of program responsibilities to Regional offices and units of government at the State and local level, and the development of allied services legislation.

Implementation of the provisions of the Social Security Amendments of 1972 (H.R. 1) involved OPE in on-going analyses of issues relative to the Supplemental Security Income Program, social service activities under Titles I, X, XIV, XVI, including proposed changes in regulations for the conduct of social service programs, food stamps and the food commodity programs, and health care and services under Medicare and Medicaid.

The passage of the Rehabilitation Act of 1973 precipitated an OPE review of the implications of that legislation for the elderly.

During the year, the Office also published "A Summary of Selected Legislative Proposals Affecting Older Americans" covering 92nd Congress proposals and an "Index of Legislation" covering legislative proposals of the 93rd Congress.

Also initiated during 1973 was a staff study on the status of social and health services definitions. The in-house study has indicated the need for uniform definitions of services, development of national standards for the measurement of the delivery of such services, and consequent movement toward more meaningful assessment of program progress.

An intensive, ongoing analysis of the effects of the energy shortage was begun late in the year and is to continue throughout 1974. Federal plans and regulations for ameliorating the energy crisis are being reviewed and commented upon for their effect on the elderly in general and the conduct of the program of the Administration on Aging in particular.

c. Evaluation

OPE developed a plan for AoA-sponsored evaluation activities during the 1974 fiscal year. Stressed in this plan has been the need for information on the elderly and services to the elderly at the national, regional, State, area, and project levels. The evaluation plan and the program evaluation guidelines relate to the overall effectiveness of AoA policies and programs and to their impact on the aging population rather than to evaluation of individual grantee management performance. To implement the evaluation plan, OPE had, by the end of 1973:

(1) begun the development of a methodology for a five year longitudinal evaluation of the Title VII, Nutrition Program. The evaluation study will attempt to measure the impact of the program in terms of its effect on the health status, nutritional status, isolation, life satisfaction, longevity, and institutionalization of the participants.

(2) continued in its efforts to develop an Older Americans status and needs assessment survey for use by State agencies. The survey tool is to be tested in March 1974.

(3) let a contract to develop the first portion of an AoA data base. The contractor has begun to collect statistical data on two of AoA's target groups, the low-income and the impaired, noninstitutionalized elderly, and to devise a data organization method to retrieve information by data item. This system will be expandable to include data on other groups which will be acquired under future contracts.

(4) funded a project with the Census Use Study Group, Bureau of the Census, to develop a system for State and area agencies to collect census and other data. This system will enable the agencies to locate and define elderly with special needs or characteristics. The demonstration system is to be developed in a State and area setting, namely Nebraska and Omaha.

During the year, a previously funded evaluation of the AoA traineeship grant program was completed. The evaluation study surveyed 17 schools which had received AoA training grant support. Under the study, a mail survey of all past traineeship grant recipients was conducted. The major purpose of the study was to determine if the traineeship grants awarded to students assisted in attracting them to the field of aging both in their study program and in subsequent work. Study results reveal that approximately 92 percent of the trainee respondents indicated that the AoA grant was a deciding or influential factor in their decision to pursue a degree with an aging speciality. The study also found that 63.2 percent of the former traineeship grant recipients were currently working in jobs dealing primarily or partly with the elderly or concerns of the aged.

II. SOCIAL SECURITY ADMINISTRATION

The Social Security Administration (SSA) administers programs which provide protection against loss of earned income due to retirement, disability or death for over 90 percent of the workers and their families in the United States. It also administers the Medicare programs, which provide hospital insurance and voluntary supplementary medical insurance protection for virtually all individuals in the United States who are age 65 or older, as well as for eligible disabled persons under age 65. Beginning January 1, 1974, the SSA also has been responsible for payments to aged, blind, and disabled persons under the new Supplemental Security Income program which has replaced the State programs of aid to the aged, blind, and disabled formerly administered as grant programs by the Social and Rehabilitation Service.

1. CASH BENEFITS

Under the retirement, survivors and disability insurance programs (title II of the Social Security Act) monthly cash benefits are paid to aged or aging persons, their dependents and their survivors. The following categories of persons can receive monthly cash benefits:

-- Insured workers between the ages of 62 and 72 who have substantially retired from gainful employment.

-- Insured workers age 72 and over, without regard to work status.

-- Insured workers up to 65 years of age who have worked a specified period of time in covered employment and have a medically determinable disability, which can be expected to last for a continuous period of 12 calendar months, and which prevents them from engaging in any substantial gainful activity.

-- Certain individuals age 72 and over who are not insured under the regular social security program.

-- Wives or dependent husbands age 62 or over of retired or disabled insured workers.

-- Wives under age 62 if they are caring for a worker's child under age 18 (or a disabled child receiving benefits based on the workers earnings).

-- Unmarried children of retired, deceased, or disabled workers when they are under age 18, or if between ages 18 and 22 and attending school full-time.

-- Unmarried children of retired, deceased or disabled workers after age 18 if they have a severe and continuing disability which began before age 22.

-- Widows or dependent widowers of insured workers age 60 and over.

-- Certain disabled individuals age 50 and over who qualify as widows, widowers, or divorced wives of insured workers.

- -- Widows under age 60, or surviving divorced mothers if they are caring for a worker's child under age 18 (or a disabled child receiving benefits based on the worker's earnings).
- -- Dependent parents age 62 or older.

Of the 29.4 million beneficiaries receiving monthly retirement, survivors or disability insurance benefits at the end of October 1973, about 22 million were age 62 or over. As of January 1973 approximately 91 percent of all persons age 65 and over will either receive retirement, survivors or disability insurance benefits or will be eligible for benefits on retirement. This proportion will grow until practically all aged persons are protected. The minimum monthly benefit for a retired worker who meets the regular insurance requirements is $84.50 under present law and will increase to $90.50 for March 1974 and $93.80 for June 1974 and thereafter under the social security legislation signed by the President December 31, 1973. For retired couples the present minimum of $126.80 will become $135.80 in March 1974 and $140.70 in June 1974. This is subject to actuarial reduction if the benefit is taken prior to age 65. For those persons age 72 and older who qualify for uninsured (Prouty) benefits the payment to a single person is currently $58.00 a month and for a couple $87.00 a month. Under the recently enacted legislation the benefit payment will increase to $62.10 and $93.20 respectively for March 1974 thru May 1974 and $64.40 and $96.60 respectively thereafter. Average monthly benefits being paid at the end of December 1973 for retired workers was $166; for retired workers and their wives $277; for aged widows $157; and for disabled workers $183.

Title XVI of the Social Security Act as amended , now provides for a new Federally administered and financed Supplemental Security Income (SSI) program for persons aged 65 and over and for the blind and totally disabled. This program was effective January 1, 1974. Initially it assures a minimum income of $140 per month for an individual and $210 per month for a couple. In July 1974 the support levels will increase to $146 and $219 respectively. Certain income disregards included in the law allow some limited additional income, and encourage beneficiaries to work when they are able to do so. Lien laws are not applicable under the new program, and generally beneficiaries may retain their homes and automobiles. Eligibility requirements and support levels are the same in all States. The States are required to protect the income level of recipients who were on their public assistance rolls for the aged, blind or disabled in December 1973 through a mandatory State supplementary payment. States also may supplement the Federal payment through an optional State supplementary payment. They are encouraged to do so by a provision whereby the Federal government will bear the cost of administering the supplements as long as the States elect to let the Federal government make the State supplementary payments. States which chose to supplement, but which prefer to administer to supplementary payments themselves, at State cost, are free to do so. Estimated payments to the aged, blind and disabled under this program in 1975 amount to $3.9 billion, of which, $2.1 billion will be to persons age 65 and over.

On December 30, 1969, the President signed into law the Federal Coal Mine Health and Safety Act of 1969. The Act was amended on May 19, 1972. Benefit payments are made under this law from general revenues to coal miners who are totally disabled due to pneumoconiosis ("black lung disease") and to widows of coal miners who died due to pneumoconiosis. These benefits are increased if the beneficiary has eligible dependents. Benefits also are payable to orphans, and in certain circumstances to totally dependent surviving parents, brothers and sisters. Many of the beneficiaries are aged because the Act permits former coal miners and widows to qualify without limitations on either age or how long ago the disability occured. In 1973, benefits paid to persons age 65 and over under this program were $612 million and in 1974 payments to such persons are expected to be $644 million. In 1975, benefits paid to aged persons will decrease to an estimated $604 million primarily because fewer new claims resulting in large one-time retroactive benefit payments will be processed in 1975. On January 1, 1974, principal jurisdiction for this program shifted from SSA to the Department of Labor. As a result, benefits paid under this program by the SSA will continue to decrease in future years.

2. HEALTH INSURANCE BENEFITS

In fiscal 1974, an average of 21.7 million persons aged 65 and over and 1.8 million disabled persons in the United States will be afforded basic Medicare protection. Under Medicare, hospital insurance beneficiaries are protected against the costs of inpatient hospital services, post-hospital skilled nursing facility services and home health services. In addition, the voluntary supplementary medical insurance program covers the cost of physicians and related services. Both parts of the Medicare program provide for payment of these costs subject to certain deductible and co-insurance amounts.

Payments to hospitals, extended care facilities and home health agencies for persons aged 65 and over under the hospital insurance program are expected to total an estimated $7.2 billion in 1974 and $8.2 billion in 1975. Supplementary medical insurance payments for aged persons in 1974 and 1975 are estimated to amount to $2.6 billion and $2.9 billion respectively.

3. SERVICES TO AGED INDIVIDUALS AND TO COMMUNITY GROUPS

The social security programs are administered through a network of district and branch offices. Local communities are served by 635 district offices, 591 branch offices, 3,437 resident stations and contact stations, and 18 teleservice centers. Every attempt is made to tailor services to individual needs and desires. Thus, all offices provide face-to-face interviewing in the office or in the individual's home, telephone service, and mail service.

Social security district offices provide information to the public and answer inquiries about the benefits administered under Titles II, XVI, and XVIII of the Social Security Act. They also receive, develop, and initially adjudicate claims for such benefits. Applicants are assisted in securing the factual information needed to determine eligibility for benefits and are advised of their rights. For adult beneficiaries who are not capable of managing their funds, a person other than the beneficiary is selected by SSA to receive the checks and is held accountable for using the benefits in the best interest of the beneficiary.

Social security offices traditionally have provided a referral service to community members, groups, and agencies. In many communities the social security office is the only point at which information and referral services are available.

In the areas of community and Government-wide planning, SSA plays a vital role. Data about the numbers of aged, disabled, survivor, and health insurance beneficiaries is invaluable in planning services to meet existing needs, as well as in long-range planning endeavors. At the national level, SSA's planning is coordinated with planning of other departments, agencies, and organizations, both public and private, such as the Department of Agriculture, Public Health Service, Administration on Aging, Social and Rehabilitation Service, Department of Housing and Urban Development, ACTION, American Public Welfare Association, National Council on the Aging, and the American Red Cross.

Similarly, regional offices engage in planning and coordination of SSA activities at the regional level as these relate to other public and private agencies and programs that serve the aged. SSA involvement in Government-wide planning and its commitment to serving the aged was demonstrated in the agency's involvement and participation in the 1971 White House Conference on Aging and subsequent follow-up. The advent of Medicare also required extensive interface with numerous organizations and facilities which serve the aged. To facilitate effective administration of the Supplemental Security Income Program, regional teams are providing important liaison between SSA and State departments of social service to assure that applicants and recipients of assistance payments are referred to both agencies as appropriate.

At the State level, SSA provides assistance to State health departments to fulfill Medicare requirements and to promote full potential for care of the aged in institutions, out-patient, and home care facilities. More recently, very extensive coordination with States was required for implementation of the Supplemental Security Income Program.

At the local level, SSA participates in interagency community planning for development of resources with many health and welfare agencies. These include representatives of health and welfare councils, local government officials, local representatives of national public and voluntary agencies such as ACTION, U. S. Department of Labor, National Council on Aging, County Commissions on Aging and senior citizens groups, American Red Cross, etc. Projects resulting from this participation often involve substantial numbers of older people recruited to perform a variety of activities throughout the community as well as in SSA offices. Examples of these activities include outreach programs such as FIND, Medicare Alert, and SSI Alert, in which older volunteers contact vast numbers of potential aged individuals to assure that all who are eligible take advantage of income, health, and welfare programs available to them. Social security offices cooperate with all such projects and provide training to volunteers on eligibility requirements, procedures, etc. While some aged workers are volunteers, other are paid nominal amounts by ACTION under the RSVP and Foster Grandparents programs or by the Department of Labor under contract with local groups serving the aged. Most older people working in social security offices are paid, and work part-time, performing clerical, and sometimes higher level functions. Projects and activities such as those described, sponsored by the government and by private agencies, have clearly demonstrated the effectiveness of older worker performance as well as advantages to the retiree and to the employing agency.

4. RESEARCH ON ECONOMIC SECURITY FOR THE AGED

The Social Security Administration research and statistical program provides information derived from the operations of the Social Security Administration system, from population surveys and from studies of related public and private income maintenance programs that is useful for continuous evaluation of the effectiveness of the social security program in providing economic security for the aged, including protection against the costs of hospital and medical care. Data are developed and published regularly in the Social Security Bulletin and its Annual Statistical Supplement, in special published reports and in various other ways to meet user requests.

Indicative of the types of information made available and of interest to officials and groups planning programs for the aged are: Continuously reported data on claims and benefit payments to retired workers and their dependents; the findings of surveys of the aged population, which provide information about the level of economic security that social security benefits support (information obtained on income includes sources of income of individuals and families, level and types of assets owned, special demands on income such as medical expenditures, etc.); special studies that show the changing share of the total national output going to the aged, what measures of income adequacy are most appropriate and meaningful, the relationship between individual and family income over the life cycle; continuing statistical series that are concerned with the totality of public and private income maintenance protections and the relative weight of the social security program in that totality; and research to measure the impact on the aged of both public and private health and medical care programs, to identify and define gaps and unmet needs under the health insurance program, and to examine and evaluate the economic consequences of health insurance program. Social Security Administration research draws heavily upon basic data in the social security system, data from the population survey program, and upon data from the Bureau of the Census, Bureau of Labor Statistics, and other statisical sources.

III. PUBLIC HEALTH SERVICE

A. HEALTH SERVICES ADMINISTRATION

Programs of the Bureau of Community Health Services are designed to ensure optimum health care for the total community. Thus, while the aged are not singled out as a specific segment of the population which warrants principal focus, the betterment of their health and welfare is promoted through various program efforts which affect the health of all age groups. Bureau activities which impact most significantly on aged populations are provided through community and family health centers, migrant health projects, health maintenance organizations and the National Health Service Corps.

1. COMMUNITY AND FAMILY HEALTH CENTERS

a. Community Health Centers

The Bureau is currently administering approximately 118 community health centers which are providing a range of preventive, therapeutic and rehabilitative ambulatory services to an estimated target population of 4.7 million persons. The centers, which include former OEO projects transferred to DHEW over the past several years, are located in both urban and rural areas scattered throughout 38 States, the District of Columbia and Puerto Rico.

b. Family Health Centers

In addition, the Bureau of Community Health Services funds 39 family health centers. Built on a prepaid group practice concept, these are designed to provide a prescribed package of ambulatory health care benefits to a specifically enrolled population residing in a defined medical scarcity area. While only a limited number of these are currently delivering services, they have an eventual target enrollment potential of 525,000.

c. Data

While data are not available on all community health centers, recent quarterly reports from 86 centers indicate that 6 percent of the total registrants are age 65 and over. These reports further indicate that this age group represented 8 percent of the MD users, and that 10 percent of the high frequency users (three or more MD encounters during the quarter) were in this age range. Thus, this relatively small proportion of registrants utilized a disproportionate amount of the services in these health centers.

We expect, also, that approximately 8 to 10 percent of those served by Family Health Centers will be elderly. Utilization data are not currently available for these centers, but they are expected to start meeting national reporting requirements during FY 1974.

2. MIGRANT HEALTH PROGRAM

The Migrant Health Program is designed to provide access to health care services for migrant and seasonal farmworkers and their families. As a group, the migrant family represents an underserved segment of the population in terms of most social and health services. The elderly migrant, generally uneducated, often unable to speak English, and living in remote rural areas without access to health services, suffers from an even more intensified lack of services. In addition, the aged person who is no longer able to participate in the work force, may find himself left behind in a home-base area as the rest of the family travels north from three to seven months of the year looking for work.

Of the approximately 338,000 migrants and seasonal farmworkers who received services in this program in 1973, 3,700 are estimated to be 65 years of age or older. Most of these are women who are traveling with families, serving as baby-sitters for their grandchildren and doing domestic chores for the family as needed.

The Migrant Health Program will continue to emphasize increased development of personal health services for migrants and seasonal farmworkers and their families. Within the often limited availability of local resources, arrangements will continue to be made by project workers for inpatient hospital care for these persons and for nursing home care, as needed, for the elderly migrant.

3. HEALTH MAINTENANCE ORGANIZATIONS

The Health Maintenance Organization (HMO) Program was created within DHEW as a result of the President's 1971 Health Message in which he encouraged their development as an alternative to the traditional fee-for-service delivery system. With the recent passage of HMO legislation, the Department is actively engaged in facilitating further growth and expansion of this program. HMOs provide, or otherwise assure the delivery of, an agreed upon set of comprehensive health maintenance and treatment services for a voluntarily enrolled group of persons on a prepaid capitation basis.

Under H.R. 1 (P.L. 92-603, Section 226) "Medicare is authorized to make a single combined Part A and B payment, on a capitation basis, to a 'Health Maintenance Organization,' which would agree to provide care to a group not more than one-half of whom are Medicare beneficiaries who freely choose this arrangement." Based on this regulation, the Department is currently completing work on the drafting of interim regulations governing the participation of HMOs in Medicare. Nearly 200 organizations have expressed an interest in participation. In addition, the requirements of Section 1833(a) (1) governing the payment of Group Practice Prepayment Plans (which cover only Part B services) will be conformed to the Section 1876 requirements. There are currently 34 direct-dealing Group Practice Prepayment Plans and 40 carrier-dealing GPPPs.

While HMO services are available to all persons in a given geographic area who enroll in the HMO, the emphasis on accessibility, prevention, quality of care, efficiency, and cost consciousness makes this health care option particularly valuable to the aged in view of their higher-than-average utilization of services.

4. NATIONAL HEALTH SERVICE CORPS

The National Health Service Corps is designed to improve the delivery of health services to persons residing in areas with critical manpower shortages. The desire is to place self-sufficient teams of health professionals which will establish successful practices in shortage areas and continue to provide services in these areas. By the end of Fiscal Year 1973 there were a total of 335 health professionals assigned to 183 shortage area communities.

As is the case with other BCHS activities, services provided through Corps projects are not specifically designated for the elderly although members of this population group who reside in the funded health manpower shortage areas are eligible for services. Most of the projects are located in rural areas -- places where there are heavy concentrations of elderly persons.

As of December 31, 1973 a total of 81 of the 183 projects are located in communities in which the elderly comprise 10 percent or more of the target population.

5. PROFESSIONAL STANDARDS REVIEW ORGANIZATION

The Professional Standards Review Organization Program was authorized by the 1972 amendments to the Social Security Act. This provision requires the Secretary to establish and support a nationwide network of voluntary, non-profit groups of local physicians to regulate the quality of health care services paid for under Medicare, Medicaid, and Maternal and Child Health Programs. The purpose of the statute is to improve the quality of health care services and to make more cost effective the expenditures for health care services financed by Titles XVIII, XIX, and V of the Social Security Act. PSRO's are to accomplish these purposes by applying sophisticated concepts of peer review through a system of voluntary local organizations, State Councils, and a National Council supported, regulated, monitored, and evaluated by the Federal Government.

The major goals of this program are: to assure that the quality of care rendered at any point within the health care system is of uniformly acceptable quality; to identify health care problems and work towards their improvement; to improve health care through medical education; to assure costs are appropriate to the level, type and location of services; to effect improvements in physician practices through use of the financing systems and sanctions, as appropriate; and to assure uniform and effective utilization review policy and practices.

PSRO's will affect about 44 million beneficiaries and recipients involving $22 billion in Federal and State Medicare and Medicaid expenditures.

In brief, PSRO's must review the medical necessity of services, the quality of care delivered, and the appropriateness of the care in terms of the level, duration, and methods of treatment. Initially, PSRO's will place emphasis on the review of institutional services, especially those provided in the acute general hospital. Eventually, the scope of their review will be expanded to encompass all facets of the health delivery system.

The implementation of this program requires the development of an innovative regulatory system that brings together the Government and the private sector in a unique cooperative relationship. In addition, the program must be made operationally effective in two massive but strikingly dissimilar programs, Medicare and Medicaid.

The following is an analysis of the priority implementation tasks that will be accomplished during 1974 and 1975: (a) Development and issuance of PSRO policies for related programs such as utilization review, medical review, and independent professional review, (b) PSRO area designation criteria and guidelines have been developed and a broad range of data was assembled during the consultation process. Area designations were announced as Notices of Proposed Rule Making in the Federal Register on December 20, 1973. Following the commenting period and analysis of the comments, PSRO area designations will be published as Notices of Final Rule Making, (c) PSRO program implementation activities will focus on the development of basic program policies, procedures, interim regulations, and operating guidelines, and (d) The Provision of technical assistance will be provided potential and newly forming PSRO's and State Councils.

In 1975 agreements will be concluded with an additional estimated 70 PSRO's and 12 State Councils for a total of 142 projects.

Technical assistance will be provided to newly formed PSRO's and PSR State Councils. PSRO's will be provided assistance and advice on the expansion of the scope of PSRO review activities. Policies, guidelines, and regulations will continue to be developed including the issuance of an operating manual for PSRO's and PSR State Councils as the program evolves through the various phases from planning, to conditional, to full operational. Evaluation activities will be initiated to assess the impact of PSRO's on health care, quality, and cost and to compare the performance of PSRO's and State Councils.

6. QUALITY ASSURANCE

When Medicare was enacted in 1965, the Secretary of HEW was required to establish national conditions of participation for a variety of providers of services to protect the health and safety of program beneficiaries. Prior to Medicare, little existed in the way of established professionally acceptable standards for some providers of services, particularly for long-term care facilities, home health agencies, and independent laboratories. Qualifications required for many types of health care manpower also were inadequate to ensure a safe level of quality of services. The Division of Medical Care Standards, working with the Social Security Administration, was assigned principal responsibility for standard-setting and surveillance of the program, and for other professional health aspects of Medicare of direct benefit to program beneficiaries.

The objective of the Division of Medical Care Standards is the improvement of the health status of Medicare and Medicaid beneficiaries by ensuring that the types, quality, and quantity of services provided under the program are appropriate to patient needs. Since the onset of the program, the effects of the standards, along with their continuous evaluation and revision, have been to promote the upgrading of individual institutions and agencies, to improve State licensure and certification programs, and to stimulate changes in national accreditation programs. In establishing standards and surveillance techniques for individual health care practitioners, problems of qualifications and availability have proved difficult. However, Medicare has helped to focus attention on problems of health manpower--from physicians to nurse aides--including their supply and the surveillance of the services they provide. Various techniques, for assuring quality of services without unduly limiting tne supply of health care personnel, including the utilization of proficiency examinations for selected categories of such personnel, are undergoing study and experimentation; and Medicare, through the Division of Medical Care Standards, is in the forefront of these efforts.

The Conditions of Participation for Skilled Nursing Facilities and Intermediate Care Facilities were revised and issued in January 1974. The Division acting as the Department's operational focal point coordinated the efforts of the Health agencies, the Bureau of Health Insurance and the Medical Services Administration in such actions. The training and enforcement efforts are now underway with Division headquarters and regional office personnel actively involved with BHI and MSA staff.

The Division has instituted several ongoing programs to promote and maintain the quality of care provided to elderly persons. Chief among these are the joint SSA/BQA program reviews of State Medicare agencies, during which evaluation is made of the effectiveness of program policy and guidelines and the manner in which these are administered in the States. Of more direct benefit to program beneficiaries is the Division's promotion of quality assurance mechanisms including utilization review, through which physicians evaluate services provided to beneficiaries to determine that such services are reasonable and necessary, rendered in appropriate settings by qualified health professionals, and performed at the right time, in the right amounts. The main thrust of utilization review activities will be to increase the effectiveness of surveillance of quality and appropriateness of services, particularly in those institutions and agencies in which the concept of utilization review was nonexistent prior to Medicare. The Division has been the principal proponent in establishing medical care evaluation studies, a mechanism for evaluating the quality and effectiveness of health services, as an integral component of the Utilization Review process. A principal and rewarding function of the Division's medical staff is to provide consultation to SSA on medical problems that arise, many of which are connected with review of the appropriateness of care provided to individual Medicare beneficiaries.

Another ongoing comprehensive program instituted in 1970 was to improve the interpretation and uniform application of Federal health care programs by State agency personnel through training and evaluation of individual surveyor performance. This program was developed to meet a specific need following the enactment of Medicare and Medicaid, and has been supported by the States, the Social Security Administration, and the Social and Rehabilitation Service, all of which have assisted in its development. The health facility surveyors who are being trained through university-based courses have a major responsibility for ensuring that nursing homes, extended care facilities, hospitals; and home health agencies provide safe and adequate care and comply with required standards in serving Medicare and Medicaid beneficiaries.

In Chicago on June 25, 1971, in remarks to a Joint Conference of the National Retired Teachers Association and the American Association of Retired Persons, the President referred to the "depressing" nature of some nursing homes. In August he announced a Plan for Action to improve the quality of care provided in the nursing homes of our country, as a result of which the Federal Program (Health Facilities Survey Improvement Program) was expanded to provide training for 2,000 State nursing home surveyors. The training programs have included basic and university-based courses for surveyors; university-based managerial courses for State survey agency supervisors and administrators; and indepth specialty courses covering various health care services. Programmed instructions for on-the-job orientation of new surveyors is also underway. Since the inception of the program 1435 State surveyors and 211 Federal employees have completed the courses.

Still another way in which the Division has a relationship to the health services for the aged is by recommending changes in Medicare policies and legislation, and in conducting studies. Some of these recommendations and studies have directly affected the accessibility, quantity, and quality of care in the Medicare program.

The Division plays a focal role in implementing the Medicare-related Social Security Amendments of 1972, with emphasis on Professional Standards Review Organization and Medicare-Medicaid State agency coordination, and in providing professional support in administering the additional benefits contained in this legislation.

7. FEDERAL HEALTH PROGRAMS SERVICE

The Federal Health Programs Service has no programs which of themselves relate directly and specifically to aging. This applies to its research and clinical care programs as well as to the programs of Emergency Health Service and Federal Employee Health. FHPS has, on occasion, provided professional personnel to assist other programs which were directly concerned with the problems of the aged. For 1973, of a total of 31,397 discharges from hospitals of the FHPS, 3,993 (12.7%) were over 65. The average length of stay for elderly men was 22.4 days and elderly women 19.6 days, compared with an average length of stay of 16.3 days for all patients. Consistent with this finding is the fact that older patients are affected to a greater extent by chronic conditions which require longer periods of hospitalization, and for similar conditions, older patients tend to receive longer periods of hospital care than younger patients.

A high proportion of elderly persons receiving inpatient services are American seamen, the primary beneficiary group cared for in PHS hospitals. The problems presented by aging seamen are similar to those presented by aging patients in general with one exception: there are probably more single males in this group than in the general population. Because of this fact, finding suitable nursing homes for their long-term care constitutes one of the real problems in meeting the needs of aging patients served by FHPS.

8. INDIAN HEALTH SERVICE

The Indian Health Service is responsible for the administration of a health program which provides comprehensive health services to approximately 498,000 Indians and Alaska Natives. Based upon the age distribution of the 1970 U.S. Census, approximately 6 percent of this population are persons age 65 and over, and about 13 percent are 45 to 65 years of age. Thus Indians and Alaska Natives are a young segment of the U.S. population.

The aging and aged persons within the purview of the Indian Health Service are reached through its program focus upon the family constellation and upon Indian and Alaska Native communities. The health and health related services provided, covering the life span of this population, have resulted in a decline of 19 percent in the crude death rate for Indians and Alaska Natives in the 24 reservation States between 1960 and 1972. In 1960 the life expectancy of the Indian and Alaska Native was 61.7 years, and in 1970 it was 64.9 years, as compared with the U.S. all races totals of 69.7 and 70.9 for those same years.

To more readily advance the health status of the Indian and Alaska Native people, and to assist this population group in the exercise of their rights as citizens, Federal and State services as available to all other citizens are utilized along with Indian Health Service health care programs. Those services available from other resources for the aged are coordinated with the IHS program to help meet the needs of the individual aged Indian and Alaska Native.

B. NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT, NATIONAL INSTITUTES OF HEALTH

1. EXTRAMURAL AGING RESEARCH

The study of the biological, psychological, and sociological aspects of aging covers a wide territory. Since it is impossible to investigate this territory in a comprehensive fashion, certain areas of special need and promise have been emphasized including biomedical aging, mental aging, and societal aging.

a. Biomedical Aging

The human organism is genetically programmed to develop from a fertilized egg to an adult. During development and after maturation various deleterious changes occur in the human body. Because the body does not possess the abilities to repair all these changes, some accumulate and result in the progressive deterioration called aging. At present, medical intervention can compensate for a small part of aging damage. One of the major aims of biomedical research is to make more extensive compensation possible. For example, intervention is already possible in the treatment of the menopause, the condition that results from ovarian aging. Probably in the future, physicians will be able to intervene more vigorously than now in the immunological deficiencies of the elderly. An understanding of the basic processes of cellular aging may open a number of therapeutic possibilities.

1) The Menopause. The female reproductive system undergoes enormous changes during the course of its development and decay. After a period of relative inactivity during childhood, ovarian activity increases dramatically at puberty. The body produces eggs and ovarian hormones in a strictly patterned reproductive cycle which, unless interrupted by pregnancy or modified by hormonal contraceptives, repeats itself with little variation until about the age of 50. At that time, and over a period of several years, ovarian activity falters and then almost completely ceases.

The hormones secreted by the ovaries through the reproductive years exert a profound influence on the maturation and maintenance of the breasts and sexual organs. The great reduction in the ovarian excretion of estrogen during the menopause and in postmenopausal years causes atrophy of tissues previously stimulated by estrogen. In addition, hot flashes and episodic sweats may occur. The severity of these symptoms varies greatly among women and is probably related to the degree of estrogen deprivation. This, in turn, depends on how much function the ovary retains and how much estrogen is produced by tissues and organs other than the ovaries. It has been thought that other types of deterioration, such as osteoporosis and atherosclerosis, become worse with estrogen deprivation. The evidence for this, however, is not strong.

It has been known for several decades that the flashes, sweats, and genital atrophy associated with the menopause can be eliminated by the administration of estrogenic hormones. However, a great deal remains to be learned about who needs this treatment, what the best preparations are, what the dose schedule should be, and what the undesirable results of such therapy may be. Complications, particularly clotting in blood vessels and stroke, have already been caused by similar hormones used as contraceptive agents. There is some evidence that these complications are more frequent in older women of reproductive age.

The activation of the ovary at puberty is initiated by pituitary hormones produced under the control of the central nervous system. The cessation of ovarian activity at the menopause, on the other hand, is due to ovarian failure.

The mechanism of this is unknown, but it does provide an example of aging in a discrete organ proceeding more rapidly than the average rate of the rest of the body.

NICHD supports research on the other mechanisms that exist in the normal postmenopausal woman to compensate for the hormones no longer produced by the ovaries. The Institute funds, by contract, a retrospective study of the effect of estrogen therapy on the incidence of stroke in postmenopausal women.

2) Immunological Changes. The immunological changes that occur with age represent an important area for study because they are large and cause serious problems in the functioning of the elderly. When sufficient knowledge about immunological function and its changes with age have accumulated these may prove to be amenable to therapy. The progressive changes in immunologic function are especially interesting in that the immune system reaches peak development and begins its progressive decline with age before many other systems have reached maturity. Immune competence at birth is low, reaches a maximum value in the teens, and thereafter declines until in old age it may be as low as 5 percent of its previous highest value.

The importance of the immune system as a defense against infectious diseases has long been known. The elderly are particularly susceptible to infectious diseases. Much evidence has accumulated indicating that the ability to tolerate a number of infections is greater in childhood than in the adult years. In addition, it is also recognized that immunologic competence may play an important role in preventing development of cancer and of autoimmune diseases. The development of means of augmenting immune competence in the later years of life would represent an advance in improving the health of older people. Research toward this end is supported by NICHD.

3) Cellular Aging. Although complex systems may be modified to control some aging manifestations, more vigorous intervention might be possible if the cellular and subcellular aging processes damaging these systems were understood. Little is known about cellular and subcellular aging. The progress of modern biology has, however, provided methodology and concepts to investigate the processes involved. Because cellular aging underlies the aging of the whole organism, NICHD places special emphasis on this area of research.

Through tissue culture and transplantation studies, scientists have learned that normal mammalian cells cannot reproduce themselves indefinitely. This fact has caused a profound change in theories of aging by emphasizing that an understanding of organism aging may have to be based on cell biology.

The cell whose limited ability to reproduce itself has been most intensively studied to date is the fibroblast. This cell, similar to most dividing cells within the body, may provide a model for them. At the same time the fibroblast has its own importance as a producer of collagen and the mucopolysaccharides that constitute the structures providing mechanical support to other cells of the human body. NICHD is supporting research on many aspects of the limited reproductive potential of fibroblasts, such as membrane, mitochondrial, and lysosomal function, protein and nucleic acid metabolism, peroxidation reactions, and hormonal responsiveness. It is hoped that these and other studies will disclose the mechanisms by which cell reproduction potential is limited and the consequence of this limitation or the effects leading to it. Such discoveries will be particularly important if they can be generalized to some other cells within the body.

b. Mental Aging

Knowledge of changes in the higher mental processes during the adult years is not complete since it is based mainly on comparisons between young and old persons. Since the younger persons have the better educational backgrounds these tests are likely to be biased in their favor. However, the results of such studies strongly suggest that there is deterioration in mental function with age. This deterioration is much more severe in nonverbal then in verbal abilities. The mechanism of this change is not known but may be related to progressive loss of brain cells that occurs with age. This decline in mental function does not incapacitate an individual and can only be detected by special tests.

Other, more serious, impairments of mental function may occur with aging. For many years, the severe cases of mental deterioration in the elderly were attributed to vascular disease. There is increasing evidence that this is not usually the case and that, in fact, most instances of such mental deterioration are due to changes in the brain cells produced by a special mechanism. The Institute is supporting studies aimed at determining and ameliorating these changes.

c. Social Aspects of Aging

The average duration of life has changed tremendously since the evolutionary emergence of mankind, and there have been concomitant changes in the population age structure. There is no reason to think that these changes will not continue and that mankind will not continue to adjust to them.

Currently the average expectancy of life at birth in the United States is 71 years. Although there are a number of countries in Northern Europe with greater average life expectancies, the differences in terms of years are not great. In no area with good statistics does the average duration of life exceed 76 years. However, a maximum lifespan of 114 years or more is possible.

In the development of the future population characteristics of the United States changes in fertility rates and changes in mortality rates will play quite different roles. Once a society reaches a point where a large fraction of its women live through their reproductive years as the United States now has, then fertility rates can influence population size much more rapidly than can any reduction of mortality rates in the post-reproductive years. This is because sustained increases in fertility for generation after generation result in exponential growth which multiplies the population by some factor every generation. In contrast, any decrease in post-reproductive mortality influences population size by an appropriate factor only at that one time.

Since fertility rates may be lower in the future, whatever changes in post-reproductive rates that occur may assume more importance than in the past. For example, with zero population, current mortality rates, and no migration, this country would come to have 16 percent of its population over the age of 65 years. Zero population growth combined with the improvement of mortality rates that may come with the control of vascular disease and cancer could lead to a larger fraction of the population living past 65. For these reasons the Institute supports research to investigate the implications of changes in mortality rates for society and for the individuals who compose it.

It is, of course, impossible to predict future mortality rates. However, various assumptions can be made and their implications evaluated. The research currently supported is concerned with evaluation of mathematical models and the implications that can be drawn at this time. Although some idea of the range of possibilities has been obtained by investigating rather extreme assumptions, much more must be done before a comprehensive view of the possibilities facing society can be formulated.

2. INTRAMURAL RESEARCH

The Gerontology Research Center (GRC) is the focal point for intramural aging research at the NIH. The 140 scientists, technicians, and supporting personnel at the Baltimore center investigate the biomedical, physiological, and psychological aspects of aging in both humans and animals. An additional 10 projects in the guest scientist program involve 70 nongovernment personnel working on projects related to aging or the health problems confronting the elderly.

New information gained this year ranged from man's continued ability to reason in old age to the fundamental mechanisms underlying many of the losses experienced by older organisms.

a. Viral Protection of Old Cells

One question asked by Center investigators is whether normal human cells lose the ability to protect themselves against viral infection when grown and aged in cultures. Normally full protection can be achieved by treating cells with specific compounds (polynucleotides) which stimulate the formation of interferon, a protective protein. Alternatively, the cells may be treated directly with interferon. Recent results reveal that the antiviral protection afforded by both agents decreases with the age of the cells and that old cells require larger amounts of protective agents. In contrast, once the cell is stimulated, the speed with which these substances are produced does not deteriorate with age. The findings suggest that the older cell's health might be maintained by developing more effective ways to stimulate protective protein production.

Viral infection of cells can also be used to test age-related deterioration of the cell's biochemical machinery. The replication of viruses within a cell requires many of these cellular components. Because viral replication continues to be effective in old cells as well as in young, some scientists conclude that a large part of the cellular machinery remains intact in old cells.

b. Metal Ions and Senescence

Minute amounts of metal ions such as copper, zinc, and magnesium are necessary for many biological processes and are present in all living tissues. The concentrations of these metal ions in cells are known to change with age. Therefore, it is important to know whether these changes cause errors in the cell's genetic message which in turn result in harmful cellular changes. Scientists at GRC have now shown that metal ions in concentrations only slightly higher than those essential to molecular genetic processes do generate significant errors. These errors include forcing interaction between the wrong kinds of cell components.

Related work in experimental animals is also being conducted.

c. Physiology and Aging

Understanding complex mechanisms underlying "normal aging" is a crucial initial step toward unraveling the still more complicated connections between aging and disease.

Progress in this area was highlighted by several trends in the Baltimore Longitudinal Study data, and development of new testing methods for this study The Longitudinal Study continues to be a most valuable resource for aging studies. It draws on a group of 600 community-dwelling volunteers, aged 20-96 years, who visit Baltimore periodically to take many physiological, biochemical, medical, and psychological tests to measure individual aging changes.

d. Cholesterol and Triglyceride Levels

Serum cholesterol and triglyceride levels show strikingly different changes with aging in volunteers. Cholesterol is a substance found in almost all normal body tissue, blood, and bile. Excessive deposits of cholesterol in the walls of blood vessels are believed to produce one form of "hardening of the arteries," arteriosclerosis. Triglycerides are compounds which make up the fats and oils in human diets.

The research reveals that the serum cholesterol concentration increases in young and middle-aged men but levels off in later life. Triglyceride levels, on the other hand, remain constant in young men and fall significantly in middle aged and older men. Through analyses of volunteer dietary habits, activities, and other variables, scientists are searching for the reasons why these age differences exist.

e. Ultraviolet Radiation and Age

Past studies of the effect of sunshine in producing skin cancers assumed that the damaging radiation spectrum was 290-320 millimicrons and that longer ultraviolet radiation wave lengths, 320-400 millimicrons, caused "tanning" and protected the skin against sun damage.

An investigator at GRC is studying the effects of age on sensitivity to ultraviolet light of different wave lengths and on the time course of these radiation effects. Preliminary findings show that longer ultraviolet wave lengths actually enhance skin sensitivity rather than having a protective effect.

f. Reasoning Ability

Reasoning is one of the most prized behaviors of man. It is also one of the most elusive for experimental study. As part of the Baltimore Longitudinal Study, scientists are studying logical problem solving to assess age changes in the ability to reason.

g. Hormones and Old Cells

Laboratory techniques perfected recently suggest that the next frontier in basic biological research will be crossed with increases in understanding of the function and regulation of cellular membrane activity. Some of the causes of aging may be related to molecular events in these membrances. Scientists at GRC are conducting investigations to learn more about the mechanisms by which important cell constituents are transported across the membranes and the role of hormones in modifying the membrane, thus regulating cell function. There is already evidence suggesting that age-related changes do occur in these important cell components.

h. Immunity and Age

Immunological studies at GRC have shown that the decline in immunity that occurs with age is the result of changes in the cells and their environment. There are two significant changes that occur: 1) a reduction in the number of parent immune cells; 2) a decrease in their ability to reproduce themselves and become efficient in producing antibodies (disease fighters).

In one recent study of aged mice, three investigators showed that aged stem cells in bone marrow have decreased ability to produce functionally effective B-cells (lymphocytes). The immune system is composed of B-cells, along with cells formed in the thymus gland (T-cells), and by acting together guard the body against infectious and other harmful agents.

Other investigations are underway to identify and characterize regulatory and precursor cells in order to determine their role in aging of the immune system. Additional studies search for ways to replenish defective immune systems in the aged and to control the diseases related to immune deficiency prevalent in the older population. These include diseases of the kidneys, joints, and blood vessels. One example is animal research testing the possible beneficial effects of caloric and protein restriction on the immune system.

i. Genetic Factors in Immunology

Genetic research focuses on metabolic and cellular changes associated with altered development and aging. Particular emphasis is on genetic factors that can influence human aging. To carry out these studies most efficiently, a tissue culture facility was established this year to grow, maintain, and store cells from young and old donors. Cell cultures have been initiated from minute skin samples of individuals with genetic disorders associated with accelerated aging. Emphasis is on the study of Down's syndrome (mongolism) a genetic disorder characterized by mental retardation and numerous other abnormalities. Individuals with Down's syndrome have lifespans averaging between 20 and 30 years. They are 10 times more prone to develop malignancies than the general population and have a high incidence of infections throughout life. In this genetic study, various biochemical methods are being used to describe cells from donors with Down's syndrome.

One study of men, aged 24 to 83 years, was begun in 1967 and completed during 1973. Initially, 300 men participated and 225 of these subjects were retested six years later. Comparisons of young and old men, based on their first performance, showed a systematic age-related decline in the proportion of men who successfully solved the first test problem (96 percent for men below age 40 and 73 percent for men over age 70).

The repeat studies showed there were definite age changes even for the select group of men who returned for second performance tests. For all age groups the proportion of subjects solving the problem in the second time was about the same as the proportion who solved it the first time. For subjects who solved the problem both times, age declines showed up only in men who were over 70 when tested orginally.

Scientists plan to explore further physiological and behavioral measures available for subjects of the Longitudinal Study. Their eventual goal is to identify variables which relate to, and may underlie, the continued high reasoning ability seen in some older men.

C. ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Persons over 65 years of age constitute more than 10 percent of the population, but they occupy 29 percent of all public mental hospital beds. About 5 percent of the aged population are in institutions of all kinds, yet they receive less than 2.7 percent of the services of outpatient psychiatric clinics.

Because of the high susceptibility of this age group to physical and mental illness, the health problems posed are far greater than would be expected on the basis of the population figure alone. While it is true that many of the mental health problems common to other age groups are also prominent among the aged, this group in addition is vulnerable to specific difficulties associated with the aging process. Some of the mental impairment of the aged is a concomitant of physical aging; approximately 85 percent of elderly persons not in institutions have one or more chronic conditions and 20 percent have an interference with their mobility. The psychological reaction to this physical process may form the basis for excess impairment that cannot be attributed to organic changes. The high incidence of depression, suicide, withdrawal, and regressive responses in older people provides a crucial area for attention by the National Institute of Mental Health. The handicaps also imposed by nonacceptance and loss of status in a youth-oriented society accelerate the psychopathological reactions occurring within older persons.

Faced with a public mental health problems of this magnitude, the NIMH has attempted to mobilize its resources to maintain, and if possible, to improve the mental health of this segment of the population. By the active support of research, the development of innovative and more effective methods of delivering mental health services, and the education and training of appropriate manpower, the NIMH is seeking to provide increased and more precise knowledge of the factors associated with mental health and mental disorder in later life, to devise means for preventing mental disorder and maintaining the psychosocial functioning of older persons, and to stimulate greater interest and more adequate programs for the elderly on the part of the various public and private agencies and institutions responsible for the mental health and welfare of the American public.

1. NORMAL AGING

Although the elderly display many of the mental health problems and concerns found in the general population, certain areas of special importance requiring focused effort can be identified and are being pursued by NIMH staff. One basic problem is the need for more accurate and detailed information about the aging process and the methods of adjusting to it. A common view of later life is one of pessimism in which abilities and satisfactions decline rapidly and with significant physical, psychological, and social deterioration seen as being inevitable. A publication emanating from an NIMH-supported project describes an intensive and comprehensive study of healthy old men in which the biomedical, psychological, social and psychiatric status of the study group was carefully studied and evaluated. Follow-up studies were conducted at five and 12-year intervals. Findings strongly indicate that while small declines in these areas can be expected normally with increasing age, severe deterioration is indicative of disease rather than aging. It is important to note that one of the significant factors associated with both mental and physical health in old age is continuing psychosocial activity and involvement and that this factor is strongly associated with longevity.

2. PREVENTION

The NIMH has consistently maintained an orientation toward prevention of mental illness throughout its history. With this in mind, a number of studies have been supported on the psychosocial factors which seem to be associated with successful adjustment to aging. One study was concerned with the male mid-life decade, another elicited the factors related to successful marriage in later life, and another is defining the congruities and conflicts which exist between older generation and younger generations. Since one of the most important bench marks of aging in our society is the retirement from work, several studies have been supported in this area. One such study, conducted by Harvard University, has resulted in a publication dealing with patterns of successful retirement and with variables predictive of successful adjustment to retirement.

3. HOUSING

The NIMH has pioneered in stimulating and supporting studies of the role that housing plays in the lives of older persons. Projects conducted by investigators at the University of California at Los Angeles have delineated the wide range of housing facilities in which older persons live and have evaluated the role that appropriate housing plays in adjustment to later life. These studies indicate that nearly the total sample surveyed disapproved of retired persons living in the same household as their children. Other projects have dealt with the effect of providing information and referral services in public housing for the aged, as well as the effect of providing medical and social services in such housing. One project is evaluating the effects of a new form of housing called "intermediate housing" at the Philadelphia Geriatric Center. This type of housing was developed through converting existing small row houses to low-cost private efficiency apartments. The residents consist of aged persons who were living in the community and who requested a social agency's help in relocating because of unsatisfactory living arrangements. This innovative housing came to the attention of the Senate Subcommittee on Housing for the Elderly of the Senate Special Committee on Aging. It was found to be so impressive that bill S2181 was introduced in the U.S. Senate in July 1973 amending the National Housing Act to provide further assistance to private nonprofit corporations for conversion of existing single family housing for occupancy by elderly persons of low and/or moderate income.

4. SERVICES

The problem of providing appropriate and adequate services to the aging clients has long been a source of concern to social agencies. A study recently completed by the Family Service Association of America addressed itself to the problems that family service agencies face in dealing with the multiple demands put upon them by such clients. The overall goal of the study was to learn whether an aging client can sustain his social, physical, and emotional functioning to enable him to live more effectively in the community through the enhancement of services with a social work team. The findings of this project indicate that the utilization of casework assistants has reduced or eliminated waiting lists where they previously existed, for services to the aged, and that more service was offered to more clients. Four out of the five agencies participating in the project succeeded in obtaining funds from their community chests or federations so that they could permanently retain their assistants when the NIMH funding of the demonstration ended.

5. PROBLEM OF DIAGNOSIS

The complexity of properly diagnosing psychiatric illness in older persons and in distinguishing between the various conditions from which they suffer is underlined by a study of differences in diagnostic processes between the United States and the United Kingdom being conducted by the New York State Psychiatric Institute. This study, which has been going on for several years, is now focusing on geriatric patients with special reference to distinction between and prognosis for organic and affective disorders. It is of interest that nearly 80 percent of the first admissions 65 years of age and over in the United States are diagnosed as organic disorders, while in the United Kingdom only 46 percent of admissions in this age group are so diagnosed. The complex relationship between these two conditions is such that one can mask the other, and means for more careful and precise differential diagnosis are badly needed.

6. COMMUNITY ORGANIZATION AND INSTITUTIONS

A particularly high risk group of elderly is found living in extremely deprived social economic conditions in our large cities. Among these persons are some who have been discharged from State mental hospitals. As a result, many disabled older persons are found living in a variety of congregate facilities in the community, including welfare hotels, apartment houses, and boarding houses. In many large cities a crucial problem has arisen because of large numbers of older persons living in run-down, single room occupancy hotels. One NIMH-supported study being conducted by Roosevelt Hospital in New York City is addressing itself to this problem. In this project the effectiveness of a comprehensive on-site treatment program on the social, psychological, and physical health of aged tenants in a hotel is being studied. The principles of community organization have been applied in organizing the tenants of the hotel to form a council to deal more effectively with the management and to consider the problems experienced by the residents, and various social, psychological, and medical services are provided through the hospital. The average age of the residents is 59, and approximately 87 percent receive welfare funds. It is anticipated that this project will provide a model of an alternative manner of providing mental health services to an extremely isolated portion of the older population.

The intricate manner in which the older person interacts with his environment is a complex problem of special importance to institutions for the aged. This importance is underlined by the fact that the great majority of the residents of such institutions display a significant degree of mental impairment resulting from organic brain disease. For the most part, the attitude toward this group has been one of pessimism in which rapid deterioration was seen as inevitable, intensive nursing care and supervisions were required, and the patient was not permitted to participate in the decisions affecting him or even to care for his own personal wants. This view was challenged in a project conducted by the University of Michigan at Ypsilanti State Hospital. In this project patients from the geriatric wards were placed in a therapeutic milieu in which a noninstitutional, more home-like atmosphere was physically created, patients' interaction was fostered, and each patient was challenged to extend his range of activities and responsibilities as he progressed through the treatment program. The program was highly successful, with practically all of the patients showing a significant degree of improvement and many of them being discharged from the hospital to alternative facilities or even to their own families and independent living. The success of the project was such that it has provided the basis for the training of personnel from a number of State hospitals, nursing homes, and homes for the aging throughout the United States with the purpose of having them apply the principles learned in the program at Ypsilanti State Hospital.

Similar results have been obtained consistently in other institutions where large numbers of mentally impaired older persons are found. At the Hebrew Home for the Aging in Riverdale, New York, it was found that even severely impaired older persons could participate in and receive therapeutic support by working in a workshop where they received actual wages supplied by performing tasks subcontracted from various industries. Also, as a result of this project a manuscript entitled Aged Patients in Long-Term Care Facilities: A Staff Manual has been published by NIMH on the training of nursing home staff to work with mentally impaired aged residents. A project at the Philadelphia Geriatric Center has demonstrated that deterioration can be retarded and that functioning may be maintained in older persons displaying a significant degree of mental impairment by individualizing treatment for such persons on the basis of their own needs as individuals. The principles emanating from projects such as these should have wide application in a variety of settings, and such applications need to be undertaken and evaluated.

A Social Work Guide for Long-Term Care Facilities was prepared under NIMH contract. The area of social services in these institutions has not previously been clarified, and this publication should enhance the knowledge of administrators, social workers, and others as to utilization of social workers.

7. TRAINING PROGRAMS

The shortage of trained mental health personnel that exists generally is reflected in its most extreme degree by the relatively small number of mental health professionals concerned with the care of the elderly. Those who work in this field have generally been accorded very low status professionally and little has been done to interest students in the mental health disciplines in the problems of the older person or to prepare them to work with this age group. An effort is being made by the NIMH to stimulate greater interest on the part of mental health training programs in providing suitable education and experience in working with older persons.

One training program inaugurated in 1971 is focused on staff employed in long-term care facilities. The NIMH program, one of a number in DHEW, is designed to improve skills and increase knowledge of nursing home personnel in the mental health aspects of long-term care with special concerns for meeting the needs of former mental hospital patients now residents of such institutions.

A continuing education project at the University of Southern California is providing training in aging for a multidisciplinary group of professionals, including general practitioners, psychologists, psychiatrists, city planners, and architects to increase their competence in dealing with mental health problems of the aged by informing them of current research findings. Training is provided through a summer institute in the Gerontology Center. The program has attracted large numbers of individuals and is generally considered a successful and outstanding program.

The training and use of paraprofessionals for work with the elderly is an important development that has taken place over the last few years. At Case Western Reserve University an experimental training project educated inner-city people for a new paraprofessional role created to meet a variety of needs of a noninstitutionalized elderly population. In a combination of classroom education and agency field experience, enrollees learned how to assist the elderly in their homes so they could maintain themselves and function at a maximum level outside institutions. This project had double value in that it provided an effective means of help to impaired older individuals as well as providing gainful and rewarding employment to individuals who might otherwise be unemployed.

The growing national concern with the problems of older Americans is evidenced by the convening of the White House Conference on Aging, the activities of the Special Committee on Aging of the United States Senate, the amount of legislation introduced in the Congress, and the numerous articles and programs on aging that have been forthcoming from newspapers, television and other media.

The aged are sometimes described as if they were a homogenous group which would lead us to believing that one solution can be found for all mental health problems of the aged. Actually, they are heterogeneous and, as in any other age group, suffer from a variety of mental health problems.

The Institute attempts to recognize these needs through its research, training, and service programs.

D. HEALTH RESOURCES ADMINISTRATION

1. NATIONAL CENTER FOR HEALTH STATISTICS

All health statistics prepared by the National Center for Health Statistics (NCHS) can be presented in terms of specific age groups. These have been summarized for the aging in a report "Health in the Later Years of Life."

Measures of morbidity among the noninstitutional population include the incidence of acute conditions and injuries, number of days of disability, prevalence of chronic conditions, and the number of persons whose activities are limited due to chronic conditions. The latter category is the measure of health status which increases most rapidly among the elderly.

These data from the household Health Interview Survey are usually presented for the broad age groups 45-64 and 65 and older so that some other characteristics which are related to both age and health can also be shown: family income, educational attainment, and living arrangements. Also reported in the interview survey are number of visits to physicians, medical specialists and dentists, episodes of hospitalization, days of hospitalization, expenditures for various types of health services, and sources of payment.

Health Interview Survey reports published in 1972 and which emphasize the aging are "Age Patterns in Medical Care, Illness, and Disability," "Home Care for Persons 55 Years and Over," and "Convalescence at Home Following Hospitalization Among Persons 55 Years of Age and Older."

The Health Examination Survey of smaller national samples of the noninstitutional population yields high quality diagnostic data on some of the chronic diseases most prevalent among older people--specific types of heart disease, hypertension, arthritis, visual and hearing defects, and dental conditions. It also provides data on several physiological characteristics (height and weight, serum cholesterol level, blood glucose level, blood pressure) and on symptoms of psychological distress. In addition, current examinations include assessment of nutritional status. In this Health and Nutrition Examination Survey, the aging have been over-sampled to insure reliable statistics.

Separate surveys are made of the residents and patients in both long and short-term care institutions--chronic disease hospitals, nursing homes, and general hospitals. These surveys provide data, classified by age and other characteristics, on utilization, diagnosis, medical and nursing care received and costs. "Charges for Care in Nursing Homes," (1972), a report from a recent Nursing Home Survey, includes data on coverage by Medicare and other types of medical assistance payments. Also published in 1972 and from the same survey were reports on "Employees in Nursing Homes" and "Services and Activities Offered to Nursing Home Residents."

Currently underway is a major national survey of 2,000 nursing homes. This survey will provide data on the operating costs of the homes and on the characteristics of employees on their staffs. In addition, data will be collected on approximately 20,000 resident patients in these homes. These data include sociodemographic characteristics, mental status, health status, assistance needed in performing activities for daily living, diagnoses, medical history and last examination, charges and source of payment, and any discharge plans. Release of preliminary data from this survey will be made in June-July 1975.

The National Center for Health Statistics also produces the national and State life tables and data on causes of death by demographic characteristics and geographic distributions of the population.

2. HEALTH CARE FACILITIES SERVICE
(Hill-Burton Program)

A primary objective of the Division of Facilities Utilization (Hill-Burton program) is to stimulate the modernization and construction of facilities needed to build up an efficient, well-coordinated network of services for the acute care, ambulatory care, long-term care, and rehabilitation of all persons, including the aged and aging. Since the enactment of the Hill-Burton program, the Service has provided assistance for the modernization and construction of 100,800 long-term care beds in chronic disease hospitals, nursing homes, and units of general hospitals.

The need for modernization and construction of long-term care facilities continues at a high level. As the aging population continues to increase, the demand for adequate nursing home care for them must be met. In addition, the enactment of the Medicare, Medicaid and other programs partially removed the economic barriers to care of the aged. State agencies report that 356,000 long-term care beds, including extended care facility beds, need to be modernized or added. In FY 1974, 19.76 million dollars were appropriated for the construction of long-term care facilities. This level of financial assistance will stimulate the modernization or construction of approximately 1,795 long-term care beds by nonprofit or public sponsors.

The aging and aged will benefit also from the construction or modernization of other health facilities under the Hill-Burton program. Hospitals, outpatient facilities, public health centers, and rehabilitation facilities are used more intensively by the aging than any other age group. Funds appropriated for these facilities totaled 165.68 million dollars in 1974. Direct and guaranteed loans up to $500 million, carrying a 3% interest subsidy, are also authorized by the 1974 appropriation.

In addition, the following services provided by the Division of Facilities Utilization contribute to improved health care of the aged and others throughout the Nation: (1) technical and professional consultation regarding all aspects of facility functional planning, design, maintenance, and construction, which is available to all public agencies, and nonprofit organizations; and (2) guide material relating to the planning, design, equipping, and construction of health facilities, which is continually being developed and distributed.

3. HEALTH SERVICES RESEARCH AND EVALUATION

The Bureau of Health Services Research is the lead agency for and major supporter of projects designed to implement the President's initiative to improve long-term care services for the elderly. In that capacity, the Bureau is responsible for the planning, design and funding of pertinent research and development activities, independently and collaboratively with other Federal agencies such as the Social Security Administration, the Administration on Aging, and the Social and Rehabilitation Service. The three priority areas on which the research and development efforts are focused are: measurement of the quality of care; development of alternatives to institutional care; and acquisition of data for future policy making and program planning. Wherever possible, efforts are directed at development of programs involving utilization of previous research findings and at working cooperatively with other ongoing research projects. A major focus of the President's initiative to improve nursing homes, provider improvement through short-term training and technical assistance, is also carried out by the Bureau.

Examples of projects supported in the area of long-term care are:

1. Development of acceptable scales that will readily monitor the quality of care rendered, relate operationally to improvements in the nursing home environment and in patient management, and are easily utilized by providers or surveyors.

2. Development and demonstration of a system for assessment of patients' needs based on a manual of descriptors of patient status developed through previous research.

3. Development of a model through which a community-based home care program can effectively reduce unnecessary institutionalization and be at an appropriate cost level.

4. Development of models aimed at improving the quality of life for the elderly through specialized living arrangements such as boarding homes and artificial families that can provide desirable alternatives to institutionalization.

5. Development of a uniform data system for long-term care patients and institutions that will permit effective planning, management and licensing of long-term care facilities as well as to implement and test this system in one State and ultimately in other States.

6. Progress in data subsystems has been expedited by electing to evaluate an existing system operated in Illinois. This system has potential for adoption elsewhere, and a contract is underway to enable the Illinois State Department of Health to give technical assistance to other States which are interested in using the system. These other States will be expected to meet the costs of their own system.

7. Provider improvement is being carried out through: State contracts to provide a wide range of training approaches, designed to demonstrate the value of a variety of methodologies for all categories of nursing home personnel; contracts with national organizations to provide an opportunity to utilize the expertise and organizational structure of professional groups providing services to nursing home consumers; and, contracts with selected long-term care facilities (designated as Centers) located in each of six Regions to train multidisciplinary teams from long-term care facilities using a combined clinical and didactic approach. Centers will be developed in the remaining four Regions within this fiscal year.

IV. SOCIAL AND REHABILITATION SERVICE

A. ASSISTANCE PAYMENTS ADMINISTRATION

Under the maintenance assistance programs, cash payments are made to needy persons for the cost of food, shelter, clothing and other necessary items of daily living.

P.L. 92-603, enacted October 30, 1972, established a national program to provide supplemental security income to individuals who have attained age 65 or are blind or disabled. The national program became effective as of January 1, 1974, since which time the Social Security Administration has been responsible for making Federal payments to eligible recipients.

Prior to that date, the maintenance assistance program supporting aged persons was old age assistance. Additionally, there were some persons over age 65 who were recipients under the aid to the blind and aid to the permanently and totally disabled programs, plus aged persons in the aid to families with dependent children program. Since January 1, 1974, these programs have continued in effect in Guam, Puerto Rico, and the Virgin Islands, and the Assistance Payments Administration retains responsibility for administering them in these areas.

The number of aged persons and the total Federal share of cash payments for maintenance assistance programs affecting the aged are shown in Table 1 below for fiscal years 1971 through 1975.

Table 1.--Number of aged and Federal share of payments

Fiscal Year	Number of Recipients	($ in thousands) Federal Payments	($ in thousands) Administrative Costs	Average Annual Payment Rate Per Recipient
71 Actual	2,128,846	$1,486,788	$105,991	$698.40
72 Actual	2,098,967	1,217,401	80,118	580.00
73 Actual	2,034,689	1,187,961	99,791	583.80
74 Estimate 1/	1,959,670	575,427	59,982	576.01
75 Estimate 2/	75,163	22,055	3,652	385.83

1/ Estimate includes one half-year payments and costs for programs affected by P.L. 92-603.

2/ Adult programs in Guam, Puerto Rico, and Virgin Islands only.

B. COMMUNITY SERVICES ADMINISTRATION

The Community Services Administration has responsibility for administration of the social services program for recipients or potential recipients of public assistance under Titles I, VI, X and XVI of the Social Security Act. A broad spectrum of services directed at assisting needy aged persons to attain or maintain the maximum level for self-care and independence for which they have potential is provided through this program. These include such services as day care, foster care, protective services, health related services, homemaker, and chore, transportation plus others that assist the elderly persons to remain in their own homes or in community living. Services are also offered which facilitate the entry into institutional care where needed and to help the individual move out of institutional care when possible. In FY 1975 it is expected that States will spend $280,000,000 Federal dollars on services to the aged.

Fiscal Year	1971	1972	1973	1974 Estimate	1975 Estimate
$(000)	$ 83,794	$170,000	$ 216,000	$ 268,000	$ 280,000
Recipients Served	519,000	755,000	1,028,000	1,218,000	1,244,000

C. MEDICAL SERVICES ADMINISTRATION

Title XIX, known as Medicaid, provides Federal matching payments for State expenditures for health care for the poor. In FY 1973, fifty-two States and jurisdictions were participating in Medicaid (Arizona is the only State not participating).

With the federalization of the adult categories on January 1, 1974, under the Supplementary Security Income (SSI) program, States are not in all cases required to provide Medicaid to all adult recipients of cash assistance under Title XVI, as was the case in the past under Titles I, X, XIV, or XVI. Limited Medicaid coverage of cash assistance recipients will apply in States which, in determining Medicaid eligibility, opt to apply any eligibility criteria from the January 1, 1972, medical assistance standard which is more restrictive than the eligibility requirements for the Federal Title XVI program for aged, blind, and disabled individuals. States which retain any eligibility factor(s) from their January 1, 1972, standard which is (are) more restrictive than the Title XVI eligibility factor(s) must deduct a person's medical expenses from his income in determining eligibility. (They are not required to cover Title XVI cash assistance recipients who have higher income or resources, or are less disabled, than the January 1972, medical assistance standard required.) As of January 1, 1974, seventeen States planned to restrict Medicaid eligibility of SSI recipients under this option.

As of January 1, 1974, thirty-two States indicated that Medicaid coverage would be available to all recipients of cash assistance under the SSI program. States also have the option of providing Medicaid coverage to persons receiving a State Supplemental payment, subject to certain limitations. In addition, States may still elect to cover certain medically needy persons who are eligible for help only with their medical bills and who do not receive maintenance payments.

States are required to provide in their Title XIX program: inpatient hospital care, out-patient care, skilled nursing home care for individuals 21 and over, early and periodic screening, diagnosis and treatment services for children under 21, physicians services, lab and X-ray services and home health services, as well as, by regulation, transportation to medical care where needed. Use of skilled nursing home services, particularly, is primarily by the aged. In addition, States may cover optional services, many of which are of particular concern to the elderly; for example, 48 offer prescribed drugs, 35 cover eyeglasses, 33 finance physical therapy, and 37 pay for prosthetic devices. Additionally, Title XIX in FY 1973 contained several provisions directed solely to those over 65: payment of Medicare premium, copayment and deductible amounts (for cash assistance recipients), and coverage of inpatient hospital services in institutions for mental diseases.

The aged account for a significant portion of Medicaid expenditures. About 40 percent of the $8.7 billion Federal, State and local program dollars was spent on care for the aged in FY 73, and it is estimated that 4 million people over age 65 received Medicaid services. For most of these persons, Medicaid was providing services which supplemented and complemented those provided by Medicare.

In FY 1973, the Medical Services Administration continued its activities in developing alternatives to institutional care. Staff are providing consultative assistance to a day hospital project and to three day center projects.

An informational document was produced describing how States could build day treatment into their Medicaid programs and was distributed to the 10 SRS Regional Offices to be used in discussing with States how they can broaden their Medicaid programs. Responses from States have been favorable, with many asking for assistance in developing day treatment services.

Some States are interested in other models developed by the American University Conference and MSA, such as a community care organization. States also see these alternatives as desirable ways for improving the health care of their citizens and for avoiding or delaying institutionalization. (Massachusetts and Wisconsin are using these alternatives to improve the cost/benefit of their Medicaid dollars.)

SRS has recommended to States that day treatment and other alternatives to institutional care incorporated into their Medicaid programs be paid for using an all inclusive rate. This has proven to be cost beneficial to the Federal Government when contrasted with separate payments for each service rendered.

States are finding alternatives to institutional care desirable means of providing for the health and well being of their Medicaid population.

(Dollars in Thousands)

	1971	1972	1973	1974	1975
Total, Medical Assistance for the Aged..........	$1,554,096	$1,778,348	$1,539,398	$2,058,232	$2,399,060

D. OFFICE OF PLANNING, RESEARCH, AND EVALUATION

The demonstration projects program in public assistance under Section 1115 of the Social Security Act provided grants for projects which were totally or partially concerned with providing a variety of services to elderly recipients in public welfare. These projects were carried out under the auspices of State public welfare agencies.

A project in three Florida counties is demonstrating a program aimed at integrating nutrition, health, social and rehabilitation services to persons 60 years of age and older. This project is stressing the volunteer and paraprofessional participation of the elderly in program planning and operation. The project focuses on specific problems of the elderly including transportation, housing, nutrition, employment, income and social isolation.

Texas, Utah, and Florida are demonstrating the value of providing homemaker services and are enthusiastic about the results, which include helping the elderly remain in their homes or return to their homes following hospitalization. In all instances, the States experimenting with the provision of homemaker services have adopted the project activity into their on-going program upon termination of the demonstration.

A project in Michigan is working to integrate public health general hospital community outreach and social services in a practical manner in cooperation with the Inkster Comprehensive Service Project for the Elderly.

Other projects involve aged welfare recipients in pre-paid health insurance plans, health maintenance organizations, and integrated services delivery centers also involve aged welfare recipients.

(Dollars in Thousands)

	1971	1972	1973	1974	1975
Section 1115 Demonstrations	642	280	125	138	25

E. REHABILITATION SERVICES ADMINISTRATION

The major goal of the Rehabilitation Services Administration's program for the Aging is to rehabilitate as many older handicapped individuals as possible into gainful employment through activities of the State-Federal rehabilitation program administered by the agency.

The Rehabilitation Services Administration endeavors to assist each individual to reach his most adequate functioning level and highest potential. This is accomplished through a diagnosis of his condition followed by various services designed to overcome his specific handicap. Throughout the process, the emphasis is on helping the individual to help himself. These services include: evaluation and medical diagnosis to determine the nature and extent of the disability to ascertain capacity for work; counseling to help in developing a good vocational plan; medical care to reduce or remove the disability; vocational training and placement into employment; and follow-up to ensure satisfactory placement.

Progress in Rehabilitation of the Aging--It is estimated that there are over 4 million people 45 years of age and older eligible for, and in need of, rehabilitation services, of whom nearly 1 million are aged 65 and beyond.

In an effort to alleviate this, State rehabilitation agencies have been intensifying their efforts to serve the aged handicapped and a steady increase in the number of these individuals has resulted. For example in FY 1959, a total of 80,739 disabled persons were rehabilitated into employment, of whom 24,275 were aged 45 and over and 1,432 were aged 65 and over. In FY 1973, a total of 360,726 disabled persons were rehabilitated into employment 84,400 of whom were aged 45 and beyond and 5,400 were aged 65 and beyond.

Training--Short-term Training courses have served to focus on problems faced by older handicapped persons and stimulate interest on the part of professional rehabilitation staff, and staff from health, welfare, and other agencies who may attend, in developing methods and techniques to cope with these problems. A recent course sponsored by the Rehabilitation Services Administration and San Diego State College focused on vocational rehabilitation and the older handicapped worker. Staff from States in Region IX attended this meeting together with staff from appropriate public and private agencies in the San Diego area.

In 1971, a Short-term Training course was conducted to prepare recommendations to be presented to the 1971 White House Conference on Aging.

Two Regional Short-term Training Courses were conducted in 1973. One was held in Region IV in Clearwater, Florida and the other in Region II in New York City. Each focused on recommendations on rehabilitation voted upon by delegates to the White House Conference on Aging. RSA staff from States in these Regions attended as well as staff from other appropriate public and private agencies in the Regions.

Special Activities in the State Agencies-State rehabilitation agencies have utilized expansion grants and Basic Support resources to expand their services to the aging disabled. For example, the Iowa rehabilitation agency has worked cooperatively with the Easter Seal Society in that State on a project for the home bound which serves a large number of older disabled people. Also, the Ohio rehabilitation agency has participated in a public housing project designed for the handicapped and senior citizens.

Currently, three expansion grants are in operation focused on rehabilitation of the aged disabled on, or near, the poverty level into employment. Public Welfare recipients are also included in this grouping. These projects are located in New York, Illinois and Massachusetts.

Social Security Disability Applicants-The Rehabilitation Services Administration coordinates with Social Security Administration in utilizing the Social Security disability applicant load as an important referral source of older disabled persons for State vocational rehabilitation services.

Future Plans--The Rehabilitation Services Administration cooperates with the Administration on Aging in various activities such as Senior Citizens Month, White House Conference on Aging and other special projects and will continue to do so.

State Rehabilitation Agencies: Rehabilitated persons 45 years of age and over and 65 years of age and over at acceptance - Fiscal years 197 -1975.

Fiscal Year	All Rehabilitants	45 years of age and over	65 years of age and over
1971	291,272	69,244	4,489
1972	326,138	79,193	4,841
1973	360,726	84,400 1/	5,400 1/
1974 1/	375,000	84,400	5,600
1975 1/	394,000	85,100	5,500

1/ Estimate

Rehabilitation Services Administration

AGING

Fiscal Year	1971	1972	1973	1974 estimate	1975 estimate
Basic State Grants	$8,542,000	$8,944,000	$8,835,000	$9.450,000	$9,380,000
Facility Improvement	204,000	223,000	173,000	149,000	144,000
Total, Rehabilitation Services	8,746,000	9,167,000	9,008,000	9,599,000	9,524,000
Rehabilitation Training	18,000	47,316	---	35,000	---
Total, RSA1/	$8,764,000	9,214,316	9,008,000	9,634,000	9,524,000

1/ For recipients 65 years of age and over

V. OFFICE OF EDUCATION

1. LIBRARY RESOURCES

Under the provisions of Title I of the Library Services and Construction Act, the Division of Library Programs provides information and advice on programs oriented to the aging which are administered by State library agencies; assists training institutions with programs designed to give librarians skills required to meet the special library needs of older persons; maintains liaison with other Federal, State, and local agencies and organizations concerned with the aging; and assists in conferences of professional and lay leaders interested in library-sponsored activities for older people.

Older Americans account for well over half of the almost 400,000 readers of talking books on discs and cassette tapes, braille books and periodicals, and other special materials available free for those unable to use conventional print because of physical disability. LSCA funds continue to be utilized in programs to identify eligible readers; publicize available services, purchase materials and reading aids; underwrite programs for taping materials in Spanish, Indian and other non-English languages as well as in English; and provide staff and equipment in Regional and Sub-Regional Libraries for the Blind and Physically Handicapped.

Library services especially tailored for the Aging fall into two general categories: those which are provided for the elderly population in institutions; and those which reach out to the elderly in the community.

Since 1967, LSCA has furnished funds for the purpose of establishing and improving library service in institutions operated or substantially supported by a State. The many aged persons residing in State institutions are among the beneficiaries of this program.

Typical of these services are the programs for geriatric patients at the Warren and the Woodville State Hospitals in Pennsylvania, and at the Brattleboro Retreat and the Waterbury State Hospital in Vermont. In addition to lending multi-media materials and providing comfortable, attractive reading, listening and film-viewing facilities, these libraries offer a variety of programs which may include films, music, poetry reading, storytelling, book talks, discussions and games.

Among the most interesting library outreach activities conducted for the aging in 1973 were:

> In California, twenty-three regional library systems operate outreach projects designed to serve the aged among other "unreached" citizens. For example, the Camino Real and Santa Clara Valley Library Systems deliver library services to older persons in convalescent and general hospitals, residential care homes, and in their own homes. This project is entitled, "Service to Senior Adults, Shut-ins and Handicapped."

In Missouri, "Pied Piper" is a multi-media mobile, operating of the Daniel Boone Regional Library in Columbia, taking library materials and programs to the elderly as well as children and handicapped persons in this predominantly rural area.

It is estimated that approximately $750,000 will be used in fiscal year 197. for projects involving the aging.

2. ADULT BASIC EDUCATION

Reports of the State grant programs indicate that older persons are involved in local adult education programs both as participants and as volunteers. In fiscal year1972, nearly 68,000 persons 55 years and over were enrolled in ABE classes. This was approximately 8 percent of the total enrollment. Enrollment in fiscal year 1973 was approximately the same number, however, in fiscal year 1974 the numbers and percentage of total enrollment are expected to increase considerably due largely to the nationwide concern for older citizens and the expanding programs for the elderly. Already several States show marked concern with this population.

3. UNIVERSITY COMMUNITY SERVICES

Community Service and Continuing Education Programs, authorized by Title I of the Higher Education Act of 1965, have initiated a number of projects designed to assist the older American. In 1973, an estimated 11,000 persons participated in 11 projects developed for older Americans in nine States at a cost of $130,000 in Federal funds. During the eight year period since its inception in 1966, about $1,390,000 in Federal funds were spent in this area, reaching some 103,000 people directly and over 110,000 through media services. In addition there were other institutional projects under this program which benefitted the older citizens but were not designed exclusively for them. In fiscal year 1975 no funds are being requested for this program.

	1971	1972	1973	1974 Estimate	1975 Estimate
Office of Education					
Research and Training............	78	----	----	-----	------
Library Resources................	840	1,015	550	750	450
University Community Services....	215	121	130	130	------
Adult Basic Education	1,346	1,534	1,800	1,800	-----1/
National Institute of Education..	----	4,835	-----	------	------
Total......................	2,479	7,505	2,480	2,680	450

1/ No funds are requested in the Budget for Adult Basic Education as a separate program, since the Administration proposes to meet this need in a new proposed consolidated education grant program, which would give States and localities greater flexibility in the use of Federal funds for education.

Obligations for Programs on Juvenile Delinquency

Agency	1973 Actual	1974 Estiamte	1975 Estimate
OFFICE OF HUMAN DEVELOPMENT:			
Office of Youth Development...	$9,994,000	$10,000,000	$15,000,000
SOCIAL AND REHABILITATION SERVICE:			
Rehabilitation Services Administration..............	18,202,000	17,688,000	18,858,000
Rehabilitation Research and Demonstration Programs......	700,000	48,000	98,000
SUBTOTAL, SRS..................	18,902,000	17,736,000	18,956,000
OFFICE OF EDUCATION:			
Elementary and Secondary Education....................	27,437,833	27,500,000	1/
Vocational and Adult Education	2,000,000	2,000,000	1/
Library Resources............	300,000	400,000	200,000
Higher Education..............	29,659	30,000	---
Educational Personnel Development.................	375,000	375,000	---
Teacher Corp..................	2,500,000	2,500,000	2,500,000
SUBTOTAL, OE....................	32,642,492	32,805,000	2,700,000
NATIONAL INSTITUTE OF MENTAL HEALTH:			
Alcohol, Drug Abuse and Mental Health Administration.......	5,250,000	8,553,000 2/	4,579,000
TOTAL OBLIGATIONS...............	66,788,492	69,094,000	41,235,000

1/ Programs previously funded under Titles I and III of the Elementary and Secondary Education Act and under the Vocational Education Act are consolidated under the proposed consolidated Education Grants Program.

2/ Includes $2,300,000 in FY-1973 funds released for use in FY-1974.

JUVENILE DELINQUENCY

Introduction

The Federal Government is deeply involved in programs to prevent and control juvenile delinquency and youth crime, as well as programs to rehabilitate youthful offenders. The Department of Health, Education, and Welfare is directly involved with various programs concerned with prevention and diversion, community-based rehabilitation, institutional services, and research and training.

The term juvenile delinquency is applied to a wide range of behaviors that young people engage in and to society's response to these behaviors, including both criminal and noncriminal behaviors. Criminal behavior are those offenses for serious crime such as homicide, aggravated assault, forcible rape, robbery, and crimes of burglary, larceny, and auto theft. Less serious criminal offenses are those of simple assault, forgery, drunkedness, drug abuse, disorderly conduct, and so on. Noncriminal behavior ranges from status offenses to dependency cases. Status offenses are offenses that would not be unlawful if engaged in by an adult (truancy, running away, curfew violations).

Juvenile delinquent is also the name applied to children who get into the juvenile justice system who have engaged in no law-violating behavior; instead these children are the victims of parental abuse, neglect, or abandonment.

Although the behaviors that are included under the term juvenile delinquency are broad, the growing national concern over the problem centers on the serious crimes committed by young people. According to the 1972 Uniform Crime Reports, 48% of the total arrests for serious crime in 1972 were for larceny, with 50% of those arrests being persons under 18 years of age. In 1972, 27% of all Crime Index offenses solved involved persons under 18. Persons 10 to 17 years of age account for about 16% of the total U. S. population, which demonstrates the concentration of involvement in this age group. Nationally, persons under 15 years of age make up 9% of the total police arrests, and 26% of the arrested are persons under the age of 18. When only the serious crimes are considered, 19% of all arrests in 1972, were persons under the age of 15 and 44% were under 18 years of age.

The youthful offender not only loses status and potential as he is drawn into the juvenile justice system but he becomes an item in the mounting cost of juvenile related crime. It has also been noted that youthful offenders have the highest recidivism rates.

Combatting these problems within the Department of Health, Education, and Welfare are programs within the Office of Human Development, the Office of Education, the Social and Rehabilitation Service, and the National Institute of Mental Health.

OFFICE OF HUMAN DEVELOPMENT

Office of Youth Development

The Office of Youth Development administers the Juvenile Delinquency Prevention Act (P.L. 92-381) enacted August 14, 1972. This Act amends the Juvenile Delinquency Prevention and Control Act of 1968.

The Office of Youth Development was created April 1, 1973, as part of the Office of the Assistant Secretary for Human Development. It incorporates the former Youth Development and Delinquency Prevention Administration from the Social and Rehabilitation Service; the Office of Youth and Student Affairs from the Office of the Secretary; and a youth component of the research and development activities from the Office of Child Development.

Youth Service Systems

Many community programs that dealt with delinquency prevention and youth development in the past had two major deficiencies: they have been single-purpose programs conducted by single agencies and their very isolation has inhibited the development of a central information source about the range of services available in a community. This single agency approach has little opportunity to influence the activities of other agencies and has resulted in fragmentation of services. Young people who may need a variety of services (education, employment, or health, for example) are required to go from agency to agency for the help they need.

The youth service system approach developed by the Office of Youth Development seeks to address these deficiencies by stimulating the development of a coordinated network of youth services on the part of public and private agencies and, through formalized agreements and delivery, to institutionalize this service network on an on-going basis in the community. The goals are to increase the access of youth to desirable roles; to eliminate premature and inappropriate negative labelling practices, including diversion from the juvenile justice system thereby reducing alientation; and to increase the likelihood that youth will develop optimally.

Youth service systems seek to stimulate the development of networks of community-based services for youth by linking together public agencies having statutory responsibility for youth (the schools, police, courts, and welfare) other relevant public and private agencies and representatives of the private sector. These linkages are achieved through formal written agreements designed to promote the reciprocal provision of services, by joint program planning designed to make the services more responsive to youth needs, and by mutual resource allocation designed to better meet pressing youth needs, and to minimize service duplication and overlap. The youth service system program provides support on a limited demonstration basis for the provision of direct services, identified by a community needs assessment, for which no other funding is available. Such support is provided for a limited time only, until the worth of the program can be demonstrated and continued support can be attracted from other funding sources.

The Office of Youth Development funding strategy is to utilize its resources as seed monies in the development of a service integration approach to the delivery of youth services. OYD funds are a catalyst in the generation of new financial support and to encourage the reallocation of existing resources towards the development of a comprehensive service delivery network in the community. This will more effectively meet the needs of all youth, with particular emphasis being place upon those in danger of becoming delinquent.

Systems funded in FY-1973 vary from community to community. They include coordination and program linkages at the local governmental level; the establishment of a formal umbrella organization involving all the major youth-serving agencies; and efforts initiated at the line agency level and progressively moving through higher levels of authority. Representation of the advisory or policy-making boards range from a mixture of governmental, public and private agency personnel and representatives of interested groups, citizens and youth with broad policy-making powers, and boards which exercise only minimal advisory powers.

Three distinct areas of major emphasis are contained in youth service systems. 1. Diversion--oriented primarily towards impacting on and changing the practices of the juvenile justice system. 2. Youth Development--directed towards a system development strategy oriented towards achieving a multi-agency level of planning, integration, and coordination or towards involving all youth serving agencies in the target area designed to provide youth with positive experiences and social roles, including their diversion from the juvenile justice system. 3. Youth Advocacy--oriented towards changing institutional practices and procedures to make them more responsive to youth needs through the utilization of advocacy and confrontation techniques.

The Juvenile Delinquency Prevention Act consists of the following:

Title I - Preventive Services authorizes grants or contracts to meet part or all of the cost of planning, establishing, or operating community-based coordinated youth service systems for the prevention of delinquency. Public or non-profit private agencies are eligible.

Title II - Training authorizes grants or contracts to pay all or part of the cost to train personnel for work in fields related to delinquency prevention.

Title III - Technical Assistance and Information Services authorizes the award of grants or contracts to any public or nonprofit private agency to render technical assistance to public or private agencies or organizations in matters relating to the prevention of delinquency, with special emphasis on the development of coordinated youth services systems under Title I.

Title III also authorizes the collection and publication of information related to programs funded by the Act. In addition, information related to other programs involved in delinquency prevention and treatment may be gathered and disseminated both to the general public and agencies concerned with the prevention of delinquency.

Title IV - Administration provides that assistance shall be limited to programs which are carried on outside the juvenile justice system (not eligible are such agencies as the police, courts, correctional institutions, detention homes, and probation and parole authorities). Also authorized is the continuing evaluation of the programs, projects, and other activities under this Act.

The term "youth services" means such services as: individual, group, and family counseling, diagnostic services, remedial education, tutoring, schools which provide education outside the traditional school system, vocational testing and training, job development, emergency shelters and halfway houses, health services and drug abuse programs, paraprofessional and volunteer programs, and community-based treatment facilities.

The term "coordinated youth services" means a comprehensive service delivery system, separate from the juvenile justice system, designed to: 1) facilitate accessibility to, and use of all youth services found within the geographic area served by such a system; 2) identify needed youth services and provide such services; 3) make the most effective use of youth services; 4) use available resources efficiently and with a minimum amount of duplication; and 5) identify types of youth to be served by the coordinated youth service system.

FY-1973 Summary

Of the $10,000,000 appropriated for fiscal year 1973, $9,994,000 were obligated; $9,755,162 for grants and $238,839 for information services and program evaluation. Ninety grants were awarded as follows:

Category	No. of Grants	Amount
Youth Service Systems..................	75	$7,433,676
Youth Service Systems in Impact Cities.	7	1,486,832
Training............................	2	99,919
Technical Assistance..................	6	734,735
Total............................	90	9,755,162

Impact Cities

In February, 1972, the Interdepartmetnal Council to Coordinate Federal Juvenile Delinquency Programs endorsed a leadership role for the Office of Youth Development in the Law Enforcement Assistance Administration's eight impact cities. The purpose was to assist planning groups in each of the cities to develop a comprehensive delinquency prevention and youth development component, and to coordinate all agency activities that provide youth services. The Council called on DHEW to use its youth service systems program to pull together all relevant services for youth--including drug rehabilitation programs; health services, educational and vocational training programs; employment opportunities; youth involvement programs; and other relevant programs and services. The eight designated cities are: Portland, Oregon; Newark, New Jersey; Atlanta, Georgia; Denver, Colorado; Baltimore, Maryland; St. Louis, Missouri; Cleveland, Ohio; and Dallas, Texas.

Training

In fiscal year 1973, two training grants were awarded. Under one grant, a total of 400 persons, representing State and community agencies and government, attended a series of workshops designed to strengthen and develop effective youth service systems throughout the United States. The other grant to the YMCA's National Outreach Training Center trained 640 outreach workers throughout the country to prepare them for effectively working toward collaboration of youth serving agencies and institutions.

Technical Assistance

The Office of Youth Development's technical assistance efforts were designed to help crucial decision-makers, private sector representatives, youth, and adults gain a knowledge and awareness of the youth service system process. These efforts were aimed at five specific groups: 1. Individuals, who because of their position in the community can influence the decision-making process--legislators, judges, representatives of business, industry, and labor; 2. individuals from the service agencies responsible for the delivery of services to or affecting youth; 3. young people as consumers who can provide meaningful input to the planning, decision-making, and implementation process; 4. community representatives, as well as parents, affecting the means and types of services delivered to youth; and 5. individuals responsible for the coordination of youth services.

Program 1974 - 1975

In fiscal year 1974 approximately 76 grants for $9,410,910 will be awarded for youth service systems including those in impact cities. Two training grants will be funded for $100,000 and one technical assistance grant for $300,000. The balance of the $10,000,000 appropriated -- $189,080 will support information services and program evaluation.

In fiscal year 1975, the amount requested is $15,000,000, an increase of $5,000,000 over 1974. Of the increase, $4,000,000 will support programs for runaways and $1,000,000 will increase the support of youth service systems. Runaway youth have become a major social problem. Little is known as to the nature and extent of the problem. There is a dramatic lack of emergency temporary shelter and sensitive counseling services, both for the young person and his/her family. In 1975, grants will be awarded for runaway centers, the development of a profile of the problems of runaway youth, and expanded training and technical assistance to cope with the overall runaway situation.

SOCIAL AND REHABILITATION SERVICE

Rehabilitation Services Administration

JUVENILE DELINQUENCY

	1971	1972	1973	1974 Estimate	1975 Estimate
Basic State Grants	$15,600,000	$15,800,000	$17,052,000	$17,640,000	$18,760,000
Innovation Grants	175,000	---	---	---	---
Expansion Grants	450,000	450,000	450,000	---	---
Rehabilitation training	2,000	2,000	---	---	---
Rehabilitation research and demonstrations	80,000	813,000	700,000	48,000	98,000
Total, RSA	16,307,000	17,065,000	18,202,000	17,688,000	18,858,000

Footnote: Funds are not earmarked for Juvenile Delinquency. The above figures are based on estimated number of rehabilitants under 20 years of age referred from correctional institutions.

SOCIAL AND REHABILITATION SERVICE

Rehabilitation Services Administration

JUVENILE DELINQUENCY

The expansion of services to the youthful offender has been developed generally under the Basic Support program in cooperation with State and Federal correctional agencies and probation offices, as well as with State training schools and municipal courts. Programs vary in scope from the assignment of part-time counselors to correctional institutions, to the installation in reformatories of comprehensive vocational rehabilitation units, including a full array of personnel, equipment, and services.

The Rehabilitation Services Administration has used its Expansion grant program extensively in developing programs for the youthful offender. Based on this experience, these activities are being made a part of the Basic State grant program as the Department implements a policy of increasing the State formula grants and relying on State discretion to determine areas of service appropriate to its specific needs.

Under its Training grant authority the Rehabilitation Services Administration has supported conferences which bring together professionals from both the correctional and rehabilitation fields to explore ways of working more closely together. Rehabilitation counselors being trained in programs supported by RSA Training grants often have an opportunity to take field training in agencies working in the field of juvenile delinquency.

Juvenile Delinquency

Rehabilitation Research and Demonstration Program

As a result of the expansion of the vocational rehabilitation program through the 1967 amendments of the Vocational Rehabilitation Act, the concept of "behavioral disorders" appeared in the vocational rehabilitation regulations as a definition of a mental disability. Vocational rehabilitation services to juvenile delinquents and other public offenders have been predicated on the presence of a mental or physical disability. Since a large percentage of juvenile delinquents and other public offenders have in the past been found eligible for vocational rehabilitation services on the basis of behavioral disorders, it follows that the elimination of that term as a mental disability in the current revision of the rehabilitation regulations will reduce the emphasis on research in juvenile delinquency.

Current research in correctional rehabilitation, which will be completed in fiscal year 1975, relates to the training of rehabilitation clients in correctional institutions as paraprofessionals, and the utilization of ex-offenders as natural leaders in community oriented rehabilitation residential programs for other disabled offenders.

	1971	1972	1973	1974	1975 Est.
Rehabilitation Research and Demonstrations	$80,000	$813,000	$700,000	$48,000	$98,000

OBLIGATIONS FOR PROGRAMS ON JUVENILE DELINQUENCY

AGENCY	1971	1972	1973	1974	1975
OFFICE OF EDUCATION:					
Elementary and Secondary Education................	$19,156,154	$20,964,449	$27,437,833	$27,500,000	$ 1/
Vocational and Adult Education....................	2,000,000	2,000,000	2,000,000	2,000,000	1/
Library Resources.................................	300,000	300,000	300,000	400,000	200,000
Higher Education..................................	85,470	56,400	29,659	30,000	---
Educational Personnel Development.................	400,000	400,000	375,000	375,000	---
Teacher Corps.....................................	868,115	1,499,150	2,500,000	2,500,000	2,500,000
TOTAL.................................	22,809,739	25,219,999	32,642,492	32,805,000	2,700,000 1/

1/ Programs previously funded under Titles I and III of the Elementary and Secondary Education Act and under the Vocational Education Act are consolidated under the proposed consolidated education grants program.

OFFICE OF EDUCATION

REPORT ON JUVENILE DELINQUENCY

(Fiscal Year 1975)

Title I of the Elementary and Secondary Education Act of 1965, P.L. 89-10, was amended on November 3, 1966 by Public Law 89-750 to include education or educationally related services to children living in State and local administered institutions for Neglected or Delinquent children.

Grants are available to State agencies for those institutions which operate a school program and to local educational agencies for other public and private non-profit institutions for delinquents. Grants are based on applications which must describe the special educational needs of the youths in the institution and propose educational projects designed to meet the most crucial of those needs. While the Office of Education administers the provisions of the Act and provides program leadership, it is the State departments of education which are authorized by Title I to approve project applications.

In the 1973-74 school year, $22,777,833 will be allocated for 46,570 eligible delinquent children living in 385 State administered institutions. At the same time, approximately $4,000,000 will be allocated for 19,395 eligible delinquent children in 315 locally administered institutions. These children are to be served through grants made to local school districts.

Since the inception of P.L. 89-750, a major effort has been made to expand and improve educational programs for institutionalized children and return these children to their families and communities with modified concepts about education, themselves and society. The emphases in programs has been toward improved, more relevant curriculum designed for the unique needs of the children, better teaching, and greater cooperation among institutions, schools and community. There is also an acute awareness of the fundamental need for relevant teacher and other related staff training as the major step for improving education in the institutions. Effective educational aid received by these children now is much less costly, to the taxpayer, in the long run. Growing relief payments and the need for ever-expanding law enforcement facilities are inevitable results if delinquent children continue unaided into adulthood as highly unproductive and disruptive products of the poverty cycle.

Actually, there are 128,063 institutionalized neglected and delinquent children in State and local institutions who are counted for computing allocations for 1974. With continued and increased funding, the opportunities are great for this program to develop the children while discovering more effective general approaches to compensatory education. The laboratory-like characteristics of education in institutions, the nation-wide scope of the relatively small and more easily managed program, and its involvement with agencies and activities concerned mainly with proverty, crime and education are factors pointing to a high level of future success.

Title III of the Elementary and Secondary Education Act, Supplementary Educational Centers and Services, enables schools to provide programs presently unavailable to children, to raise the quality of educational services already offered, and secondary education programs to serve as models. Fifteen percent of programs funds is mandated for projects serving handicapped children. Other funds are mandated for projects in guidance, counseling and testing.

Originally, the Commissioner made grants directly to local education agencies. Beginning in fiscal year 1971, 85 percent of Title III funds were administered by

State educational agencies, with fifteen percent to be used at the Commissioner's discretion within the State.

Several of the Title III projects have components dealing with the problem of juvenile delinquency; and State departments of education generally fund some projects related to dropout prevention. However, specific information is not available as to the amounts obligated in this area. It is estimated that approximately $660,000 was obligated in fiscal year 1973, and that the same amount will be obligated in fiscal year 1974.

In 1975, the Title I and Title III programs will be included in a new consolidated education grant legislative program.

Vocational education is being offered within correctional institutions as a part of a total program to rehabilitate those with anti-social behavior. Young people, secure in the knowledge that they have a salable skill, are less apt to be recidivists after their release from an institution. Such education also helps to make their academic education more relevant as they can relate it to subjects which can lead to a lifetime interest and career.

The following States reported examples of programs for juvenile delinquency:

Indiana has special target programs in thirty school corporations including: Indianapolis, East Chicago, Michigan City, Gary and South Bend for socioeconomically disadvantaged youth, juvenile delinquents and dropouts.

Cooperation and coordination with other State and local agencies provided vocational education services for 373 disadvantaged persons in institutional-type setting in Kentucky. The agencies were: The Department of Child Welfare through Lynwood Girls' Center, Kentucky Reception Center and Jewel Manor, serving 133 students, and Barkley Boys' Camp, serving 90 students; the Fayette County Fiscal Court through the Day Treatment Center, serving 34 students; and the Department of Corrections in cooperation with the Bureau of Rehabilitation Services through Eddyville Penitentiary, serving 90 students, and Pee Wee Women's Prison, serving 26.

In New Jersey training was provided for 320 inmates at Trenton, Rahway, and Leesburg State Prisons as the result of coordinated efforts between the Department of Education, Labor, and the State Law Enforcement Planning Agency. Training is offered in auto mechanics, carpentry, electricity, masonry, welding, auto body repair, building service and maintenance, electronics, and graphics.

The Texas Department of Corrections with the Vocational Education Division cooperating has established the Windham Public School District to enable inmates to improve their opportunities in the labor market upon their release.

The multi-agency program for detained and probationary youth at the Arizona Juvenile Detention Home, has been expanded to include pre-vocational education in the areas of trade and industrial education and office education, serving youths. In addition, vocational skill training in the area of service station mechanics is providing training for 80 to 100 youth.

All of the above programs were coordinated with Vocational Rehabilitation, State Employment Welfare, Correctional, and other related agencies.

If one considers that some of the dropouts and the potential dropouts may be potential delinquents, vocational education is providing the opportunity for these young people to come back to school, take short courses in a concentrated area of study, and leave school better prepared for immediate employment possibilities. Other schools are designed mainly to serve the potential dropout. Such schools as the Vocational Arts Center in Norwalk, Connecticut, the Work Opportunity Center in Minneapolis, Minnesota, and the Beggs Education Center in Pensacola, Florida are examples of this. They have low student-faculty ratio, permit students to enter and leave when they feel they are prepared for work, and gear the faculty towards a team approach.

In fiscal year 1975 this activity will be included in a new consolidated education grant legislative program

Under the Library and Construction Act (LSCA), Title I, projects are funded which benefit many juvenile delinquents whether they live in State or local institutions or in their own homes. Under this State-administered Act, public library services are extended in areas where they are inadequate; and libraries are improved in residential facilities operated or substantially supported by the State.

Increasingly, public libraries are developing outreach projects which take appealing multi-media materials into inner city neighborhoods, migrant camps, detention homes, half-way houses and other places not usually reached by more conventional library services. Bookmobiles, storefront libraries and "instant" libraries are attracting former "non-users", including many young people. Libraries with outreach services cooperate effectively with other agencies in conducting crime prevention, drug education and post-release programs.

An example is Cleveland (Ohio) Public Library's service to many "special" children and youth who cannot use the library in the ordinary way. Its Outreach Services include regular services by skilled, experienced librarians at the Children's Aid Society, the Children's Home, and the Detention Home.

The new expanded services of the District of Columbia Public Library, programmed for youth, including delinquents, provide another example.

In 1973 the new Special Services Division began weekly bookmobile service to Youth Center No. 2 located at Lorton, Virginia. The 250 young inmates are enthusiastic about the service, borrowing many items from the bookmobile collection and making many special requests for material from the main library. An Advisory Council of five inmates keeps the library staff informed on the interests of the inmates and the kinds of film, discussion and lecture programs they want.

Branch libraries in the District of Columbia serve half-way houses for young narcotic addicts and others. The Public Library's most recent program, which promises to attract neighborhood youth, is the establishment of instant community libraries and kiosks to serve as satellite libraries throughout the city.

Since 1968, juvenile correctional facilities have been among the State institutions eligible for grants under LSCA. Usually an institution receives a grant for one or more years for the purpose of developing its library, extending services to all residents, and providing qualified staff. The institution or its parent State department then assumes responsibility for financing and administering the library and the State library agency continues back-up services, i.e., consultative and training,and interlibrary loan of books, films and other materials.

In Nevada, the Girls Training Center at Caliente and the Youth Training Center at Elko receive annual LSCA grants which have been used to purchase print and non-print materials, audio-visual equipment, and furnishings, and to pay the salaries of part-time librarians.

An outstanding need over the years has been for suitable library quarters. In 1972 a new library was opened at the Girls Training Center, and construction begun on a new library (opened in 1973) at the Youth Training Center. The cumulative results of the projects far exceed the face value of the Federal grants which in fiscal year 1973 amounted to $4,680 for the Girls Center and $5,840 for the Youth Center.

In several States, the State library agency contracts with public library systems to serve the State institutions located within their borders. In Illinois, for instance, the Bur Oak Library System with headquarters at Joilet, received LSCA grants for two years to develop a pilot project to establish libraries in the six State correctional institutions (three of which are juvenile) in its area. The institution libraries are branch libraries and thus members of the system.

Teacher Corps corrections projects, as well as standard projects, operate over a 2 year period. During FY 1973 two 6th cycle projects, Fordham University and Sacramento State College, completed their second year of operation. The Fordham project had teaching interns working in New York City special schools and in a court diversion program. In the Sacramento project teams of interns served in State, county, and community youth correctional facilities as well as the public schools. In both of these projects teachers were trained to work with the delinquent population. Through the projects public schools were able to test alternative educational programs in an effort to assist special school populations.

Four 7th cycle corrections projects were funded in FY 1973. These included the University of Southern California and the University of Oregon, projects that were refunded for two additional years to allow them to build upon initial project experience. These projects emphasized training teachers for youth correctional programs and assisting the public schools in providing improved educational programs for students returning from correctional facilities. The remaining two 7th cycle Teacher Corps interns worked in community rehabilitation programs for youthful offenders. The other new project, which was jointly run by the New Jersey State Department of Education and Montclair State College, placed teaching interns in State and county adult prisons.

In FY 1974 the four 7th cycle projects described above completed their second year of program operation. FY 1974 also included two projects being funded for a first year of operation as part of the 8th cycle. Fordham University and Sacramento State College, described above, were both refunded to allow them to build upon initial project experience.

In the past Teacher Corps has funded a variety of projects which placed teaching interns in several types of correctional facilities. Priority in future projects will be to assist the public schools in developing and testing improved educational programs for delinquents, youth offenders, and students with serious behavior problems.

Title I of the Higher Education Act of 1965 pioneered in bringing college and university resources to bear upon the community problem of juvenile delinquency. As more substantial amounts of money became available through other programs in Health, Education, and Welfare and the Department of Justice, activities supported by Title I diminished. However, a few projects of an experimental nature are still supported and they include the training and counselling of youth in correctional institutions; and helping disadvantaged out-of-school young people to rediscover their academic abilities and pursue further training. In 1973, 3 projects in 3 institutions were activated at a cost of $29,659 in Federal funds. There were 440 participants. In fiscal year 1974, we estimate that $30,000 will be applied to juvenile delinquent projects with approximately 450 participants. No funds are being requested for the Title I program in fiscal year 1975.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

National Institute of Mental Health

Delinquent behavior is a major social and political problem in American society. Almost half of all persons arrested in the United States last year for serious crimes, (e.g., homicide, robbery, and burglary), were under 18 years of age, while three-quarters were under 25. Research supported by NIMH indicated that almost 90 percent of the young people interviewed in a self-reported survey of delinquent behavior confided that they had committed an act for which they could have been brought before a juvenile court. However, fewer than 3 percent of the acts reported were detected by the police and fewer than 1 percent of those offenses were recorded as juvenile delinquency.

Understanding the causes and dimensions of delinquency and promoting remedies is a complex task. First, delinquent behavior stems from the interaction of biological, psychological, social, economic, and other factors. Furthermore, whether or not a particular pattern of behavior is considered "deviant" or "delinquent" depends on societal norms, reactions, and an administrative judgment of persons who make decisions regarding the processing of such individuals.

Given this premise, it follows that "delinquency" involves societal definitions and labels applied to certain types of behavior believed to require official sanction and control. A particular act may be viewed as delinquent in one jurisdiction, but as tolerable yet annoying behavior in another; similarly, acts which some consider delinquent may be viewed as "mental illness" by others. The same deviant behavior, therefore, may be defined quite differently depending upon who the deviant person happens to be, the persons who observe or complain about the behavior, the circumstances under which the judgment is made, and the availability of alternative societal problem-solving resources. Consequently, in view of the vague, unreliable, and inconsistent labels and definitions ascribed to deviant behavior, it is imperative that efforts to better understand and cope with such problems focus predominantly upon the actual behavior.

At the same time it is important to learn more about the factors which lead to the application of different labels (e.g., "delinquency," or "mental illness") to similar behavioral acts, the application of the same labels to different behavior, and also the factors which determine that no labels at all will be applied. The labels themselves can be important since different consequences may result from their application.

In recognizing that the same behavior may well be perceived, evaluated, labeled, and handled differently as a function of varying social contexts, the National Institute of Mental Health is concerned with the prevention, control, and treatment of deviant behavior which may be defined either as mental illness or as violations of the criminal law. The Institute's role, therefore, in the area of delinquency--inextricably related to its emphasis on understanding human behavior--is to develop and disseminate knowledge about this special area of societal concern. In focusing on behavior rather than labels, there is both potential and actual overlap of "client" populations of the criminal justice and mental health systems. Deviant and maladaptive behaviors must be studied within the same broad context of the behavioral, social, and biological sciences as normal and adaptive behavior. To confine studies of social deviance to offenders will limit and seriously constrain our understanding of these complex phenomena.

Needed Knowledge on Delinquency-Related Behaviors

Basic to the development of improved means for the prevention, control, and treatment of delinquency-related behaviors is the need for more precise knowledge on the sources and dimensions of these behaviors. Such information can add significantly to scientific understanding of psychological and social forces within an individual that affect mental health and behavioral performance. In addition, such information can add greatly to the understanding of social forces that operate on an individual, help to influence behavior, and also have a major role in developing policy decisions with respect to the handling of individual behaviors that are troublesome, offensive, threatening, or harmful to others.

Juvenile Behaviors

Several studies using longitudinal, age-cohort, and survey research techniques are expected to provide important information on the dimensions of delinquent behavior.

One study involves analysis of police and other records on the delinquent careers of all boys born in the year 1945 who lived in Philadelphia from their 10th to their 18th birthdays. It was found that of the 9,945 boys who were the subjects of this study, a total of 3,375 had at least one recorded contact with police by their 18th birthday; the 627 boys who had five or more recorded contacts with police were responsible for more than 50 percent of all the offenses known to have been committed by the entire group of boys, including about 70 percent of all the robberies, aggravated assaults, and homicides. The findings from this research suggest that while most delinquents "drop out" of the criminal justice system, the major prevention and treatment efforts ought to be invested in the hard-core cases who commit the most serious offenses. Furthermore, these data can provide additional insights into the situational influences that contribute to delinquency and the manner in which police tend to view and respond to delinquent behavior.

A longitudinal study investigating the transition of nonmetropolitan youth from adolescence to adulthood is underway. Youth who were sophomores in the high schools of a nonmetropolitan Western county in 1964 have been followed to learn of the extent to which pressures toward juvenile and young adult deviance originate in problems of adolescent stress. The study is also examining the competing commitments to education, work, family, and community on the maturational reform process and the effect of wartime military service on maturation and deviance. Such data have important and theoretical implications concerning the occurrence and maturational process of delinquency. These studies will provide data that will make it possible to compare metropolitan to nonmetropolitan delinquency and deviance for the first time.

Violent Behaviors

Individual violent behaviors are of concern since they are the most harmful to society and most frequently involve serious acts.

An important area of scientific inquiry concerns the possibility that individuals with biological abnormalities may engage disproportionately in such behavior. The NIMH is supporting several studies to determine the extent (prevalence) of chromosomal abnormalities in different population groups. Another study is examining possible interactive relationships between perinatal brain damage and later antisocial behavior; the investigators are examining the birth records of 9,000 children in Denmark, where a system of medical recordkeeping makes this type of study possible.

Development of Community-Based Treatment Models

There is increasing social concern about the prevention and reduction in confinement of troublesome juveniles in training schools and related total institutions. Despite professed remedial and therapeutic objectives, the actual results of such institutionalization are often destructive to the youth and even appear to exacerbate existing problems. To facilitate non-institutional treatment programs the NIMH has been concerned with the development and testing of new community-based treatment models suitable for implementation by local communities. The interest is to develop, test, evaluate and refine an experimental program that appears to hold promise of effectiveness and replicability as a community-based answer to problems of delinquency or crime. The various models being developed represent treatment packages which can readily be exported elsewhere with minor modification to adapt to local problems, conditions, or settings.

Juvenile Problems

Community-based treatment models have been developed to deal with problems of children and youth.

The Achievement Place project has involved the development and testing of an intensive community treatment program for adolescent boys as an effective and economical alternative to institutionalization. Achievement Place is a community-based, family-style residential halfway house for six to eight boys between 11 and 16 years of age. The therapeutic approach and rehabilitative techniques utilized in the home by the "teaching parents" have been derived from basic learning principles developed by experimental psychologists and utilized in a wide variety of fields. These learning principles are used to influence the social and interpersonal behavior of the youngsters, their school behavior, their relations with parents and peers, and their development of self-control skills. This program has established ties with the juvenile court, the department of welfare, schools, and parents. The model group-home treatment also features the close and active involvement of an advisory board drawn from members of the local community in the planning and operation of the program. To meet the wide demand for application of this outstanding model, a training component has also been developed to train "teaching-parents." Likewise, a "how-to-do-it" manual and other user-oriented materials have been produced to facilitate ready utilization of this treatment model. It is anticipated that by FY 1975 at least 45 of these group homes will be operating in communities located in different parts of the nation, and supported largely--if not even entirely--by State and local funds.

An investigator in Oregon has been working with the application of social learning concepts toward the development of intervention strategies in dealing with socially aggressive behaviors such as fighting, stealing, setting fires, and running away from home. The project is attempting to account for those interactions which maintain the occurrence of these behaviors, develop intervention techniques in the home and schoolroom to prevent the occurrence of these behaviors, and to train families and other social agents who interact with the child in these settings to detect early signs of these behaviors and to apply appropriate intervention techniques. The significance of the research is seen in terms of developing a community-level model for the prevention of delinquency. A practical and effective early intervention program to help parents prevent future delinquent behavior is indicated as the anticipated result. Further, the intervention techniques developed in the study are seen as models for teaching other professionals in the schools, courts, and mental health facilities who deal with delinquent and pre-delinquent children.

A project closely aligned with the previously mentioned research effort is attempting to develop and evaluate a program of research and training aimed at supplying community agents at the caseworker or counselor level with training in behavioral intervention strategies which have been shown to be effective in treatment of the out-of-control child and his family. Community agents from such agencies as child welfare, juvenile court, mental health clinics, and school counseling services are trained in social learning theory, data collection and interpretation, and behavioral modification techniques for intervention in family and school settings.

A project in Maryland has utilized learning and reinforcement principles and procedures for improving performance of adolescents who have displayed serious behavioral and academic problems while attending public schools. The project is developing training methods, educational and interpersonal curricula, data collection systems, etc., which can be used by a public school system within the existing school budget, personnel, and normal school hours.

A longitudinal research study indicates that short-term intensive intervention at an adolescent crisis period can alter delinquent boys' academic learning, personality functions, and overt behaviors in ways that foster positive, productive adjustment to society. The study, a comprehensive vocationally oriented psychotherapy program begun 10 years ago, involved treatment of delinquent boys through a flexible combination of services offered by a single counselor. The program initially was focused on job placement, and job-related concerns served as a matrix for all other therapeutic efforts. A recent 10-year followup shows that eight of the ten boys in the experimental group made positive, constructive adaptations and are productive members of society. In contrast, only two of the control group members have reasonably stable life styles and minimal involvements with the law. This rigorously controlled study of brief therapeutic intervention during adolescence had long-term beneficial effects. Several aspects of these research findings warrant careful consideration as they relate to social policies and issues surrounding American youth: The study indicates that adolescence is an opportune time for intervention. It provides a fresh outlook at school dropouts, suggesting that some of our programs for them might be reshaped. It shows that treatment personnel must know community resources, must have basic counseling skills, and above all must be flexible in terms of activities and techniques applied to specific problems. The project was relatively inexpensive--in fact, the cost was negligible when compared to that of criminal prosecution and institutionalization of delinquent youths. Most of all, the program stresses the importance of work experience for young people as an initiation experience into the real world of adult economic activity and as an arena for significant personality development.

Problem Behaviors and Larger Social Unit

The NIMH has also been concerned with community-based treatment models aimed at larger social units in order to affect greater numbers of individuals. A number of research and training projects have been conducted with the Oakland police department in California. This work started with an experimental training program for police officers who had become involved in an unusually high number of violent encounters with citizens. Thus, it appeared that the officers were themselves contributing, in some degree or other, to the violent interactions. The training program assisted the police officers to make use of behavioral and social science techniques in analyzing their own behaviors and those of the citizens with whom they came into contact. In a second phase of this project, the officers developed five treatment models for reducing violent behavior in their community: (1) special training for police recruits aimed at violence reduction through changes in the police subculture; (2) a family crisis intervention program; (3) a landlord-tenant crisis intervention program; (4) a special education program using peer intervention techniques for violence-prone officers identified through regular screening of police arrest reports; (5) a special education program for citizens involved in assaults on police.

Mental Health and the Legal System

The fields of law and mental health are both concerned with problem behavior of individuals. The courts frequently request mental examinations for the purpose of assisting determinations on issues such as pretrial competency, exculpatory insanity, sexual psychopathy, civil commitment, and presentence evaluation, etc. In addition, the courts and the criminal justice system generally have been moving to the position that many types of problem behaviors traditionally handled within the province of the corrections system can be dealt with far more effectively outside that system--and at far less cost to society--provided suitable alternatives are available. Such diversion efforts have emphasized the greater role of the mental health systems and agencies.

Several projects supported by NIMH are concerned with the need for empirical criteria on which to make decisions about a wide variety of difficult law and mental health issues. It also is important that psychiatrists, psychologists, and other mental health professionals consulted by the courts use more precise and empirically based criteria in order to avoid the confusions between therapeutic and the strictly legal concepts in the making of judicial decisions.

One project is concerned with the development of more precise and legally relevant criteria for determining competency to stand trial. The significance of this research is underscored by the fact that pretrial competency is by far the most frequent issue leading to involuntary hospitalization of persons who become involved in the criminal justice process.

Another project is studying the ways in which the concept of "dangerousness" is used by mental health, legal, and judicial agents in handling mentally ill law-violators. This project is also attempting to develop improved criteria with respect to the assessment and prediction of "dangerousness" as a legal and medical basis for involuntarily committing an individual to a mental institution and for subsequently retaining the person in such an institution.

A third project is developing empirically based criteria for assessing the "adequacy of treatment" provided to persons who are involuntarily committed to mental institutions. Such criteria would be of much assistance to courts and to mental health personnel.

Training

The NIMH has been concerned with training mental health service professional and behavioral and social science researchers in the delinquency field. Given the continuing gap between service needs and the availability of mental health manpower, the NIMH has been moving in the direction of providing support for experimental training models for service professionals and nonprofessionals. The emphasis has been on developing more innovative, effective, and efficient training and manpower development models aimed at improving the functioning of service delivery agencies, for example, the use of nonprofessionals (including ex-offenders) to work as probation officer-case aides. Moreover, as policies and procedures for handling and treating juveniles change, the NIMH has been concerned with developing more appropriate and effective models for training manpower to meet these emerging needs.

Finally, and consistent with the experimental nature of these projects, the NIMH is interested in learning more about the effectiveness of such training models. For this reason, many of the experimental training models have an additional and independent evaluation component to assess effectiveness of the training and its general impact in reference to the needs and objectives underlying these efforts.

Training Community-Based Service Personnel

Growing out of research with the group home treatment programs (Achievement Place in Lawrence, Kansas), is a training project to develop a practical model for educating husband and wife teams known as "teaching-parents." The trainees learn how to set up such a program in a new community setting; to manage a token economy to help motivate the youths to learn new appropriate behaviors and avoid problem behaviors; and to interact, teach, and supervise the youths in a nonaversive, nonconfronting manner while maintaining a friendly, home-like atmosphere. The teaching-parents also learn to counsel and work with the youths' natural parents, and establish and maintain good public relations with the school, neighbors, social welfare agencies, the juvenile court, police, and the community.

Training Evaluation Researchers for Community-Based Programs

Numerous social action and service programs have been supported by State and local agencies to meet problems associated with delinquency. In addition, various groups in society, such as youth and minority group members, have developed informal community-based programs designed to treat their members whose behavior is defined as deviant by the larger society. While both formal and informal organizations and groups may provide services and generate innovative methods of treatment, rarely do these programs provide adequate and systematic evaluation of their efforts. One reason for this lack of assessment has been the absence of qualified manpower. Typically, agency evaluation efforts are more concerned with broad and basic statistics and budgetary accounting than with more systematic and substantive evaluation of program effectiveness. In order to address this need, the NIMH is supporting a project to train students in a specially designed 2-year Master's degree program, with particular concentration on evaluative skills relevant to social action programs related to problems of crime, delinquency, and social deviance.

Monograph Series

One series of short monographs is intended to inform administrators, decisionmakers, community leaders, and other interested persons about research results in significant crime and delinquency topics that are also of mental health interest. These monographs, by pointing out gaps in knowledge, have also suggested directions for future NIMH program development. This monograph series has included: The Juvenile Court: A Status Report; Diversion from the Criminal Justice System; Community Based Correctional Programs: Models and Practices; Graduated Release; Civil Commitment of Special Categories of Offenders.

Another series of longer monographs has been produced under contract by a number of outstanding authorities and has been devoted to the thoughtful and in-depth discussion of important issues in the crime and delinquency area. Several of these monographs have been adopted for use in educational courses given by colleges, universities, and police academies. Examples include: Perspectives on Deterrence; Legal Sanctioning and Social Control; The Functions of the Police in Modern Society; Instead of Court: Diversion in Juvenile Justice; Development and Legal Regulation of Coercive Behavior Modification Techniques; Correctional Treatment in Community Settings; Not the law's Business: An Examination of Homosexuality, Abortion, Prostitution, Narcotics, and Gambling in the United States; Competency to Stand Trial and Mental Illness;

and Routinizing Evaluation: Getting Feedback on Effectiveness of Crime and Delinquency Programs.

In addition, there is a series of Research Reports in an effort to make available information gained from research programs to other researchers, program administrators, and others who are involved in the crime and delinquency and mental health fields. The two reports published to date include Achievement Place: A Model for Delinquency Treatment and Helping Schools Help Children.

In summary, the NIMH has been engaged in an experiment to develop and identify appropriate program objectives, integrate research and training into a unified strategy to achieve these objectives, and also to facilitate information dissemination and research utilization. Such efforts have been designed to make the program more accountable in addressing critical and social policy and problem areas in the delinquency field with models and strategies necessary for social action.

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I

INTRODUCTION

This report describes the population research and family planning activities of the Department of Health, Education, and Welfare.

Population research and family planning activities in the Department of Health, Education, and Welfare include support of services--making family planning information and services available and accessible; training--meeting the professional and lay manpower needs in health, social services, and education; research--promoting and supporting research and research training in the biomedical and broad behavioral aspects of fertility, sterility, population dynamics and program implementation; and public education--increasing opportunities for sex education, public understanding of human sexuality, and information about family planning and population growth.

Family planning services, as an integral part of adequate medical care, have been routinely and easily available to the majority of the population. In his message to the Congress, President Nixon emphasized that "...no American woman should be denied access to family planning assistance because of her economic condiition." There are about five million women among the poor and near-poor whose access to adequate family planning services depends upon subsidization. Under the Social Security Amendments of 1967 (PL 90-248), such services are available through a variety of sources to some of those who want but cannot afford them. The Social Security Amendments of 1972 (PL 92-603) require that family planning services and supplies be made available under Medicaid to all individuals of childbearing age who are eligible under the State plan and who desire such services and supplies. In addition, the enactment of the "Family Planning Services and Population Research Act of 1970" (PL 91-572) assists in a major way in making comprehensive family planning services available to persons desiring such services.

Legislative Highlights - FY 1968 Through FY 1973

1. On January 2, 1968 the Social Security Amendments of 1967 (PL 90-248), which included the Child Health Act of 1957, were enacted. This Act established categorical project grants for family planning services and required that not less than 6 percent of the monies appropriated for Maternal and Child Health under Title V be obligated for family planning services.

2. On December 24, 1970, President Nixon signed into law the "Family Planning Services and Population Research Act of 1970" (PL 91-572). This Act was passed to assist in making comprehensive voluntary family planning services available to all persons desiring such services.

3. On October 30, 1972, President Nixon signed the Social Security Amendments of 1972, PL 92-603. This Act made it mandatory to inform all recipients of Aid to Families with Dependent Children (AFDC) of the availability of family planning services and to provide or contract for services to all eligible persons desiring them. The Act imposes a penalty of one percent per annum on the Federal share of AFDC funds on States which fail to provide these services to eligible persons desiring them. In addition, the Act increases the Federal share of matching for family planning services under Title IV-A -- AFDC -- to 90 percent from 75 percent and increases the Federal share for family planning services under Title XIX -- Medicaid -- to 90 percent

from a variable formula with a range from 50 to 83 percent Federal matching.

4. On June 18, 1973, PL 93-45 extended the funding authorizations in PL 93-572 one additional [illegible] to June 30, 1974.

The tables that follow list some [illegible] functions carried out by DHEW agencies.

Table 1 summarizes HEW family planning programs for delivery of services by function, local delivery agency, and HEW operating agency with funding and program responsibility.

Table 2 summarizes other HEW population and family planning programs (research training, education, and evaluation) by function and HEW operating agency with funding and program responsibility.

These tables follow:

Table 1

DHEW Programs for Delivery of Family Planning Services by Function, Local Delivery Agency, and DHEW Operating Agency

Function	Local Delivery Agency	DHEW Operating Agency with Funding and Program Responsibility
Medical Services (either as separately organized services or integrated into larger systems of maternal or comprehensive care), Information, Counselling, and Referral	Hospitals and Clinic Services	HSA -- Indian Health Service -- Federal Health Programs Service -- Bureau of Community Health Services ADAMHA -- National Institute of Mental Health SRS -- Medical Services Administration -- Assistance Payments Administration
	Health Departments	HSA -- Indian Health Service -- Federal Health Programs Service -- Bureau of Community Health Services SRS -- Medical Services Administration -- Assistance Payments Administration
	Voluntary Health Agencies	HSA -- Indian Health Service -- Federal Health Programs Service -- Bureau of Community Health Services SRS -- Medical Services Administration -- Assistance Payments Administration

Table 1 (Cont'd)

DHEW Programs for Delivery of Family Planning Services by Function, Local Delivery Agency, and DHEW Operating Agency

Function	Local Delivery Agency	DHEW Operating Agency with Funding and Program Responsibility
Medical Services (either as separately organized services or integrated into larger systems of maternal or comprehensive care), Information, Counselling, and Referral	Private Physicians	SRS -- Medical Services Administration -- Assistance Payments Administration
Information, Counselling, and Referral only	Public Assistance Agencies	SRS -- Community Services Administration -- Medical Services Administration -- Assistance Payments Administration
	Voluntary Social Agencies	SRS -- Community Services Administration -- Medical Services Administration -- Assistance Payments Administration
	Employee Health Services	HSA -- Bureau of Community Health Services Federal Health Programs Service

Table 2

Other DHEW Population and Family Planning Activities by Function and DHEW Operating Agency

Function	DHEW Operating Agency with Funding and Program Responsibility
Training Programs for Population and Family Planning	
1. Short-term Pre-service and In-Service Training of:	
(a) Physicians, nurses, other professional health personnel	HRA -- Bureau of Health Resources Development HSA -- Bureau of Community Health Services ADAMHA -- National Institute of Mental Health CDC
(b) Social workers and other public assistance personnel	SRS -- Community Services Administration -- Assistance Payments Administration -- Office of Research and Demonstrations ADAMHA -- National Institute of Mental Health
(c) Teachers	OE ADAMHA -- National Institute of Mental Health
(d) Subprofessional workers	SRS -- Community Services Administration -- Medical Services Administration HSA -- Bureau of Community Health Services HRA -- Bureau of Health Resources Development OE -- Adult and Vocational Education

Table 2 (Cont'd)

Other DHEW Population and Family Planning Activities by Function and DHEW Operating Agency

	DHEW Operating Agency with Funding and Program Responsibility
2. Curriculum Development for Above Programs	HRA -- Bureau of Health Resources Development SRS -- Community Services Administration NIE OE
Research Training in Population and Family Planning	NIH -- National Institute of Child Health and Human Development HSA -- Bureau of Community Health Services ADAMHA -- National Institute of Mental Health CDC
Education Programs	
1. Sex and Family Life Education at Elementary and Secondary School and College Levels	OE ADAMHA -- National Institute of Mental Health
2. Professional Schools	
(a) Physicians, nurses, and other health professions	HRA -- Bureau of Health Resources Development HSA -- Bureau of Community Health Services
(b) Social workers	SRS -- Community Services Administration -- Office of Research and Demonstrations

Table 2 (Cont'd)

Other DHEW Population and Family Planning Activities by Function and DHEW Operating Agency

Function	DHEW Operating Agency with Funding and Program Responsibility
(c) Teachers	OE
3. Curriculum Development for Above Programs	SRS -- Community Services Administration HRA -- Bureau of Health Resources Development OE ADAMHA -- National Institute of Mental Health
Research	
1. Reproductive Physiology and Contraceptive Development; evaluation of safety and possible adverse effects	NIH -- National Institute of Child Health and Human Development FDA
2. Social Research	SRS -- Community Services Administration -- Office of Research and Demonstrations HSA -- Bureau of Community Health Services ADAMHA -- National Institute of Mental Health HRA -- National Center for Health Statistics NIH -- National Institute of Child Health and Human Development NIE

Table 2 (Cont'd)

Other DHEW Population and Family Planning Activities by Function and DHEW Operating Agency

Function	DHEW Operating Agency with Funding and Program Responsibility
3. Administrative Research	
(a) Utilization studies (b) Demonstrations in innovative service delivery mechanisms (c) Evaluation methods	SRS -- Community Services Administration -- Medical Services Administration -- Assistance Payments Administration -- Office of Research and Demonstrations HSA -- Bureau of Community Health Services HRA -- National Center for Health Statistics -- Bureau of Health Services Research and Evaluation
4. Facilities	
Construction	HRA -- Bureau of Health Resources Development
Evaluation	
1. Overall Evaluation and Coordination	Office of the Secretary -- Assistant Secretary for Health and Scientific Affairs Deputy Assistant Secretary for Population Affairs Assistant Secretary for Planning and Evaluation

Table 2 (Cont'd)

Other DHEW Population and Family Planning Activities by Function and DHEW Operating Agency

Function	DHEW Operating Agency with Funding and Program Responsibility
2. Medical Services Evaluation	HSA -- Bureau of Community Health Services HRA -- Bureau of Health Services Research and Evaluation ADAMHA -- National Institute of Mental Health
3. Social Services Evaluation	SRS -- Community Services Administration -- Medical Services Administration -- Assistance Payments Administration -- Office of Research and Demonstrations ADAMHA -- National Institute of Mental Health

II

OFFICE OF THE SECRETARY

Office of the Assistant Secretary for Health

The Office of Population Affairs, under the direction of the Deputy Assistant Secretary for Population Affairs, serves as a focal point for Department policy and program coordination. The Deputy Assistant Secretary has full line authority and responsibility for directing population research and family planning service activities within the health agencies. P.L. 91-572, the "Family Planning Services and Population Research Act of 1970," establishes by statute the Office of Population Affairs and delineates the functions of the Office as follows:

> The Secretary shall utilize the Deputy Assistant Secretary for Population Affairs--
>
> (1) to administer all Federal laws for which the Secretary has administrative responsibility and which provide for or authorize the making of grants or contracts related to population research and family planning programs;
>
> (2) to administer and be responsible for all population and family planning research carried on directly by the Department of Health, Education, and Welfare or supported by the Department through grants to, or contracts with, entities and individuals;
>
> (3) to act as a clearinghouse for information pertaining to domestic and international population research and family planning programs for use by all interested persons and public and private entities;
>
> (4) to provide a liaison with the activities carried on by other agencies and instrumentalities of the Federal Government relating to population research and family planning;
>
> (5) to provide or support training for necessary manpower for domestic programs of population research and family planning programs of service and research; and
>
> (6) to coordinate and be responsible for the evaluation of the other Department of Health, Education, and Welfare programs related to population research and family

planning and to make periodic recommendations to the Secretary.

In addition, the Office of Population Affairs serves a direct staff function within the Office of the Secretary. This function comprises advising the Secretary, through the Assistant Secretary, on policy and new legislation; participation in legislative and budgetary planning; prepartion of reports on Departmental and interdepartmental activities for the Secretary and the Congress. The Office also prepares staff documents for the Secretary and any required for the White House.

In addition to direct coordination of programs within DHEW, the Office works in close cooperation with, and gives leadership to, family planning activities of other Federal agencies.

A continuing partnership between the Government and other concerned organizations is essential. The past work of private agencies in fields related to population and family planning has laid a foundation on which the official agencies continue to build. Therefore, the Office of Population Affairs has maintained effective liaison with interested public and private organizations.

Close communication is maintained with the population centers of major universities so that training can be geared to actual needs as they are revealed in ongoing DHEW programs.

In order to stimulate concerned professional and citizen groups, the Office of Population Affairs provides leadership at regional meetings, conferences or other activities which will help develop family planning resources.

The Office of International Health, a staff office to the Assistant Secretary for Health, has responsibility for the overall administration of the Scientific Activities Overseas (Special Foreign Currency Program) appropriation. This appropriation enables the six health agencies--CDC, ADAMHA, FDA, HSA, HRA, AND NIH--to utilize U. S.-owned excess foreign currencies to support health research, research training, and other health-related activities in designated foreign countries. During Fiscal Year 1975 funds will be available for the health agencies' use in the Arab Republic of Egypt, Burma, Guinea, India, Pakistan, Poland, and Tunisia.

Authority for the Program is provided by section 104(b) (3) of Public Law 83-480, the Agricultural Trade Development and Assistance Act of 1954. as amended; and, Section 3 of Public Law 86-610, the International Health Research Act of 1960.

Despite a number of obstacles to the development of new population and family planning projects in the excess currency countries during recent years, this area continues as an important component of the PHS Special Foreign Currency Program. There are presently 18 ongoing population and family planning projects, representing a total obligated cost of over $4,000,000 equivalent in foreign currencies. These projects include studies in the biomedical and social sciences. Studies in the biomedical sciences include basic research in reproductive biology, the development of new methods of fertility regulation and the evaluation of the safety and efficacy of fertility-regulating methods currently in use. Research in the social sciences seeks to determine the relationships between population size, growth, composition, and distribution and the general welfare or quality of life, measured from a variety of viewpoints.

During Fiscal Year 1974, one new project was funded. This is a study of the physiology of the liver and related phenomena in contraceptive-treated bilharzial women. This project will be carried out in Egypt where it is estimated that 40% of the population is infected with bilharziasis. The work will be carried out by the Al-Azhar University in cooperation with Wayne State University and the National Institute for Child Health and Human Development. Also in Egypt, a project to develop techniques and models useful for studying the theoretical impact that demographic variables have on other variables was initiated at the American University in Cairo. Additionally, two long-term studies of the safety of oral contraceptives, which are being conducted in Yugoslavia under agreement with the Food and Drug Administration, were approved for additional funding through the new U. S.-Yugoslav Joint Fund for Scientific and Technological Cooperation. The Office of International Health, on behalf of the six health agencies, made a grant to this fund.

Several projects directed toward a clearer understanding of the reproductive process, especially male fertility, are under development and review for possible funding in Fiscal Year 1975. These include proposals concerned with hormonal control of spermatogenesis, human sperm capacitation, and early states of human placentation. Estimated new obligations during Fiscal Years 1974, and 1975, are $700,000 and $957,000 equivalent respectively.

The Office of International Health also provides field consultation to the Agency for International Development family planning projects and project design team, especially in African countries. Continuing technical consultation on project design, implementation, evaluation and reports was provided to AID/Washington and approximately 14 AID contracting institutions during the past year.

The OIH staff also responds to AID bureau and field requests for family planning materials and personnel recruitment assistance. To accomplish this, the staff must keep abreast of family planning services, training programs, communication/health education technology and resources relevant to AID population programs.

A CENTO Workshop on Health Education in Family Planning was planned and conducted by Office of International Health staff in 1973.

Office of the Assistant Secretary for Planning and Evaluation

The Assistant Secretary for Planning and Evaluation has primary responsibility for the preparation of the five-year budget plan and the Department's program memoranda. This office is also responsible for the overall evaluation of the Department's programs.

The Office of the Deputy Assistant Secretary for Health Planning and Analysis works closely with the Office of Population Affairs in the development of appropriate planning documents, program memoranda, and evaluation studies.

Office of the Assistant Secretary for Human Development

In July 1969, the Office of Child Development (OCD) was established in the Office of the Secretary of HEW to serve as a point of coordination for Federal programs for children and their families and to act as a national advocate of services for children. On April 1, 1973, OCD became a part of a new Office of Human Development at HEW which focuses on groups of Americans with special needs.

While the Office of Child Development does not directly operate any programs on family planning, Project Head Start and other OCD demonstration programs, such as Home Start and Child and Family Resource Programs, make social services available to parents. Social worker aids and health specialists in these programs are in contact with community agencies that conduct planned parenthood education and distribute comprehensive family planning literature. The Office of Child Development does not directly distribute information on family planning, but all publications encourage parents to space their children and to talk to a physician or social worker about planned parenthood.

III

PUBLIC HEALTH SERVICE

Food and Drug Administration

Summary of Programs Related to Population Research and Family Planning

Under the authority of the Food, Drug and Cosmetic Act of 1938, as amended, the Food and Drug Administration (FDA) evaluates contraceptive drugs for safety and effectiveness before they are marketed and maintains surveillance over the drugs after their approval.

The first oral contraceptive agents were approved by the FDA for general use in 1961 after some years of research, testing, and evaluation. By 1974, there were over 40 such agents on the market.

Studies are being carried out under contract to evaluate the experience of human populations utilizing oral contraceptives. FDA is supporting studies in human and animal populations to investigate reported or suggested side effects.

Although the Food and Drug Administration does not have premarketing controls over most contraceptive devices, it maintains surveillance over such devices to ensure their safety and efficacy. There are currently no standards of manufacturing or pre-marketing investigation required by law. However, the FDA has taken steps to set standards for consumer protection.

The Obstetrics and Gynecology Device Panel has been chartered and held its first meeting on January 7, 1974. This Panel will classify devices into three regulatory categories, identify and recommend standards, and define specific device problems.

The FDA established Advisory Committee on Obstetrics and Gynecology continues to assist in activities related to family planning. This Committee published its "Second Report on the Oral Contraceptives" in August 1969. The Committee has assisted in revising oral contraceptive labeling, in updating guidelines for clinical investigations of oral contraceptives, in formulating FDA policy on influence of estrogen content of oral contraceptives in their thromboembolic action, and has deliberated the problem of the tumorigenic actions of certain steroidal contraceptives. This year, the Committee plans to update its 1968 "Report On Intrauterine Contraceptive Devices."

FDA consults and works with representatives of the pharmaceutical industry and the academic community in the planning, conducting and evaluation of studies to obtain data concerning the safety and efficacy of drugs for use as contraceptives. In addition, FDA provides opportunity for consumer or other interested parties to communicate and incorporate their views into the proposed consumer information materials that accompany the market package to assure clarity of information that is being conveyed to the user.

The agency also maintains close liaison with regulatory agencies in foreign governments, the Agency for International Development, and organized family planning groups.

The activities of the Food and Drug Administration do not include provision of services or training programs which might be utilized by the recipients in family planning projects. Of more direct concern to the FDA is the development of adequate information to assure the safety and effectiveness of those methods, both pharmacological and mechanical, which are being promoted by such programs. To this end, several research projects have been initiated and are continuing.

The carcinogenic and diabetogenic potential of certain oral contraceptive steroids is under investigation in long range studies in Rhesus monkeys and beagle dogs at the International Research and Development Corporation at Mattawan, Michigan. These studies employ three investigational compounds and one estrogen widely used in oral contraceptives. The design of these investigations follows the protocol which was prescribed by FDA to the pharmaceutical manufacturers in 1967, and under which already marketed as well as investigational compounds are currently being investigated by the sponsor. Since initiation of these studies, three investigational products tested by manufacturers have been found to induce mammary tumors in beagle dogs. Two marketed formulations, containing two of the tumorigenic (in dogs) progestins have been withdrawn by the manufacturers. The long-range design of the investigations prescribing drug administration for seven and ten years to dogs and monkeys respectively should provide some indication of the possible carcinogenic hazard to long-term human users of the contraceptives.

A study of the possible effects of oral contraceptives on renal, bladder, and ureteral function and the incidence of renal tract infection was initiated during May 1969, at the University of Rochester. A comprehensive evaluation of renal function was performed, and a prospective study of the occurrence of bacteriuria was performed in a population treated with a standard oral contraceptive preparation. The final report is being prepared and will be available later this year.

Supplementary studies concerning the safety of oral contraceptives have been developed utilizing funds from the PL-480 program in Yugoslavia.

One of the studies was performed at the Institute for Mother and Child Welfare, Zagreb, Yugoslavia. The purpose of this investigation was to assess the effect of selected oral contraceptives on carbohydrate and lipid metabolism. Three hundred women were studied over a three-year period, with a final report currently under preparation.

Another study under PL-480 support has been initiated at the University Teaching Hospital for Obstetrics and Gynecology, Ljubljana, Yugoslavia. The study has two objectives: To determine whether there is any relationship between the use of oral contraceptive drugs and abnormalities in cervical cytology, and to determine whether there is any relationship between the use of oral contraceptive drugs and fertility after drug discontinuation or the development of congenital abnormalities in the offspring of women using these drugs within three months of conception. Over 30,000 women have been entered in the study of cervical cytology. The outcome of pregnancy study is progressing satisfactorily, and a final report will be available during 1974.

A third study is continuing at the Institute of Hygiene and Social Medicine in Sarajevo, Yugoslavia. Early studies have suggested that the use of hormonal contraceptive drugs may produce abnormalities in cervical cytology and an increased rate of spontaneous abortions.

A population of 11,000 women and 7,000 newborn infants will be followed to determine the relationship between these drugs and cervical cancer in women and congenital abnormalities among offspring.

A fourth study is being conducted in Belgrade, Yugoslavia and involves a three-year investigation of the effect of oral contraceptive use on coagulation mechanisms. Completion of this study is anticipated in September, 1974.

The FDA recognizes that Prostaglandins may have significant potential in family planning. Therefore, it is monitoring ongoing research and has developed master protocols for pharmacological and clinical investigation of these products in the field of population research. FDA may, in cooperation with other government agencies, initiate some of the projects outlined in the protocols. Prostaglandins for use as an abortifacient was approved for marketing during the last quarter of calendar year 1973. Phase III studies are progressing in its use for the induction of labor at term.

On January 12, 1970, the Commissioner of Food and Drugs issued a letter to all practicing physicians in the United States. The letter pointed out that oral contraceptive labeling had been changed in order to fully inform patients of potential adverse effects. In June of 1970, the FDA required that all packages of oral contraceptives contain a statement warning users about the risks of oral contraceptives and referring them to a leaflet available through their doctor or clinic.

Proposed revisions to the oral contraceptive labeling directed to the physician were presented to the Obstetrics and Gynecology Advisory Committee on November 29, 1973 for their evaluation. When finalized the proposed revised labeling is being put into use along with revised informational material directed to the consumer.

In the June 5, 1971, Federal Register, the Commissioner of Food and Drugs published a proposal to make intrauterine implants which incorporate heavy metals, drugs or other added substances, new drugs. Thus, a completed and signed "Notice of Claimed Investigational Exemption for a New Drug" must be submitted to cover clinical investigations to obtain evidence that such contraceptives are safe and effective. An approved New Drug Application is required for marketing such articles. Three such applications are currently undergoing evaluation with the agency.

FDA maintains continuing liaison with appropriate groups within the Department since certain family planning clinics supported by the Department may provide suitable patient populations and investigative staff to perform the studies required by FDA in carrying out its surveillance responsibilities.

The FDA maintains a reporting system which receives information on adverse reactions from various types of contraceptives and serves as a clearinghouse for such information.

Health Services Administration

Summary of Programs Related to Family Planning

The Health Services Administration (HSA) is the major administrative support agency for Federal programs of subsidized family planning services.

In the HSA, family planning services are provided by the Indian Health Service (IHS), the Federal Health Programs Service (FHPS), and the Bureau of Community Health Services (BCHS). The BCHS administers programs formerly administered by the National Center for Family Planning Services (NCFPS), the Maternal and Child Health Service (MCHS), and the Community Health Service (CHS).

Review and approval of services project grant applications is carried out in the DHEW Regional Offices. The Regional Family Planning Program Directors serve as coordinators for family planning within the Regional Offices.

The Bureau of Community Health Services administers programs under the "Family Planning Services and Population Research Act of 1970" (PL 91-572), Title X of the Public Health Service Act, and Title V of the Social Security Act as amended by Section 508 of the "Child Health Act of 1967," (PL 90-248). This latter Act specifies that not less than 6 percent of the annual appropriations under Title V of the Social Security Act shall be for family planning services. In addition, Title V authorizes grants to health departments, hospitals and any public or private nonprofit voluntary organization for up to 75 percent of the cost of providing family planning services.

The broad purposes of the program, set forth in PL 91-572 include:

1. to assist in making comprehensive voluntary family planning services readily available to all persons desiring such services;

2. to improve administrative and operational supervision of family planning services;

3. to enable public and nonprofit private entities to plan and develop comprehensive programs for family planning services;

4. to develop and make readily available information (including information materials) on family planning to all persons desiring such information;

5. to evaluate and improve the effectiveness of family planning service programs;

6. to assist in providing trained manpower needed to effectively carry out family planning programs.

The BCHS administers family planning programs under Title V of the Social Security Act including programs of formula grants to States, grants for comprehensive maternity and infant care projects and related training and research grants.

In addition BCHS administers programs which include family planning services which are authorized as part of comprehensive health programs and programs for services to seasonal and migrant farmworkers and their families. These programs are authorized under the "Comprehensive Health Planning and Public Health Services Amendments of 1966," (PL 89-749), "The Partnership for Health Amendments of 1967," (PL 90-174), and grants for health services for domestic agricultural workers and their families (PL 87-692 and 89-109).

The Federal Health Programs Service of HSA is responsible for direct health services to certain Federal beneficiaries. The basic Public Health Service Act, (PL 410, 78th Congress, 58 Stat. 683, 1944), and as amended, particularly Sections 321-346 and the Dependents Medical Care Act and its amendments (PL 84-569) provide beneficiaries with comprehensive inpatient and outpatient medical services. This service also administers the medical assistance program for Cuban refugees under the Migration and Refugee Assistance Act (PL 87-510). Family planning services are included in these programs. Family planning information and counselling is provided to Federal employees through the Federal Employee Health Program authorized by PL 79-658.

The Indian Health Service provides comprehensive health services, including family planning to American Indians and Alaskan natives under PL 83-568.

Health Resources Administration

Summary of Programs Related to Family Planning

The National Center for Health Statistics (NCHS) derives its authority in population from the general data collection and research provisions of Sections 305 and 313 of the Public Health Service Act, and the transfer of certain functions of the Census Bureau relating to vital statistics to the Public Health Service. NCHS is responsible for collecting and analyzing the wide range of health and demographic statistics needed for health planning and program evaluation.

The Bureau of Health Resources Development develops, supports, and evaluates State and areawide health planning programs that work to improve the health status of their respective populations. These programs consider the whole range of health concerns including family planning.

Center for Disease Control

The Center for Disease Control is authorized by the Public Health Service Act to train Epidemic Intelligence Service (EIS) officers. Some individuals in the program are being trained in an epidemiological approach to evaluating family planning and population programs.

Alcohol Drug Abuse and Mental Health Administration

The National Institute of Mental Health is authorized to serve as the principal focus for research and training in the behavioral and basic sciences related to the causes, diagnosis, treatment, and prevention of disorders in the biological and psycho-social factors that determine human behavior and development. Under this broad mandate many activities related to family planning are supported.

Health Services Administration

Current and Projected Population and Family Planning Activities

The Bureau of Community Health Services administers programs of grants to providers of family planning services. Service projections for the organized programs based on data from the National Reporting System for Family Planning Services (NRSFPS), some State and local systems, and surveys of agencies not included in these systems, indicate that 3,214,000 individuals were served by organized family planning programs in FY 1973.

The organized program has served more people each year of operation and has increased services from 863,000 individuals served in FY 1968 to over 3 million in FY 1973. The program served 23 percent more people in FY 1973 than in FY 1972.

Estimates of individuals served by organized family planning services programs in FY 1971 and FY 1973 are shown by Region and State in Tables 3 and 4. Throughout the nation, the increase in services from FY 1971 to FY 1973 was 70 percent. Regions VII, VIII and X more than doubled the number served; Region IV almost doubled the number served; all other Regions increased the number served substantially.

The number of women receiving services from organized programs who were members of families with incomes below 150 percent of poverty was estimated to be 2,310,000. Private physicians were estimated to have served another 1,350,000 women from families with incomes below 150 percent of poverty.[1] The total number of women in families below 150 percent of poverty who were served in FY 1973 was estimated to be 3,660,000.

Tables 5, 6, and 7 provide information based on reports submitted by the States. Tables 5 and 6 show the number of women receiving family planning services through State programs supported in part by Maternal and Child Health formula grants from the Federal Government which are authorized under Title V of the Social Security Act. Table 7 shows the number of women receiving family planning services through Maternity and Infant Care Projects supported by categorical Federal project grant funds under SSA Title V. These women are a part of the more than three million served by organized programs.

Under maternal and child health formula grants, States are assisted in extending and improving their services for the promotion of the health of mothers and children, especially in rural areas. The States have broad discretion in the use of these funds, but the programs are generally preventive health services in nature.

As a condition of State plan approval, the plan for maternal and child health services must provide for the development of demonstration projects with special attention to family planning services for mothers in needy areas and among groups in special need. Acceptance of family planning services must be voluntary and not a prerequisite of eligibility for the receipt of services under the plan. The Amendments further require a State to make a satisfactory showing that it is extending the provision of services under its plan, including family planning services, with a view to making such services available to all parts of the State by July 1, 1975.

1/ 150 percent of poverty in March 1973 was $6,620 for a non-farm family of four.

TABLE 3

INDIVIDUALS SERVED IN ORGANIZED PROGRAMS, BY REGION, FY 1971 AND FY 1973*
(In Thousands)

Region	FY 1971	FY 1973
U. S. Total	1,889	3,214
I	71	129
II	267	472
III	216	331
IV	350	666
V	272	449
VI	271	433
VII	66	138
VIII	37	81
IX	290	409
X	50	106

*Totals may not add due to rounding.

TABLE 4

INDIVIDUALS SERVED IN ORGANIZED PROGRAMS, BY REGION AND STATE, FY 1971 AND FY 1973 1/ 2/

(In Thousands)

Region and State	FY 1971	FY 1973
U. S. Total	1,888.8	3,214.3
Region I	71.2	128.9
Connecticut	14.8	25.9
Maine	6.4	13.2
Massachusetts	32.0	62.0
New Hampshire	2.4	5.1
Rhode Island	13.5	13.9
Vermont	2.1	8.7
Region II	266.8	472.4
New Jersey	34.4	75.1
New York	232.4	397.3
Region III	215.6	331.1
Delaware	5.7	10.2
D. C.	25.0	33.7
Maryland	56.1	73.3
Pennsylvania	72.2	113.7
Virginia	47.2	83.4
West Virginia	9.4	16.8
Region IV	349.8	666.4
Alabama	33.0	62.2
Florida	63.9	143.1
Georgia	63.0	95.5
Kentucky	31.2	50.0
Mississippi	29.3	54.0
North Carolina	55.7	112.1
South Carolina	32.4	74.9
Tennessee	41.5	74.5
Region V	271.8	449.0
Illinois	67.2	77.6
Indiana	25.2	44.5
Michigan	68.6	143.0
Minnesota	21.9	40.4
Ohio	81.0	124.9
Wisconsin	7.9	18.5

Region and State	FY 1971	FY 1973
Region VI	270.5	433.0
Arkansas	26.3	33.8
Louisiana	67.2	115.6
New Mexico	19.3	32.8
Oklahoma	29.9	56.2
Texas	127.7	194.6
Region VII	65.8	138.2
Iowa	14.5	20.8
Kansas	12.3	30.2
Missouri	30.0	69.2
Nebraska	9.0	18.0
Region VIII	37.4	80.8
Colorado	25.5	41.8
Montana	2.3	9.3
North Dakota	1.0	4.3
South Dakota	2.4	11.8
Utah	5.1	11.1
Wyoming	1.0	2.5
Region IX	289.9	408.8
Arizona	27.4	45.6
California	250.5	339.2
Hawaii	6.8	12.1
Nevada	5.1	11.9
Region X	50.0	105.8
Alaska	6.1	7.2
Idaho	1.9	10.1
Oregon	13.2	31.3
Washington	28.8	57.2

[1] Estimated by extrapolation from 1972 data

[2] Totals may not add due to rounding.

TABLE 5

Number of Women Provided Family Planning Services
in Maternity and Infant Care Projects
Fiscal Years 1973, 1972 and 1971

Total - U. S. Region and State	1973 Provisional	1972	1971
TOTAL	114,866	124,892	134,685
Region I	3,575	5,643	4,941
Connecticut	952	1,091	1,150
Maine	143	6	
Massachusetts	1,726	3,855	3,328
New Hampshire	-	-	-
Rhode Island	754	691	463
Vermont	-	-	-
Region II	18,302	20,201	21,957
New Jersey	817	449	622
New York	16,093	18,094	19,143
Puerto Rico	1,392	1,658	2,192
Virgin Islands	-	-	-
Region III	[illegible]	16,960	19,553
Delaware	[illegible]	-	-
Dist. of Columbia	[illegible]	7,855	5,615
Maryland	1,322	2,076	6,939
Pennsylvania	3,596	4,386	4,218
Virginia	1,093	1,090	1,245
West Virginia	1,537	1,553	1,536
Region IV	43,990	42,198	35,244
Alabama	4,900	4,497	2,998
Florida	16,084	15,637	12,580
Georgia	17,505	16,405	14,631
Kentucky	431	558	552
Mississippi	932	849	815
North Carolina	1,434	1,380	1,185
South Carolina	2,704	2,872	2,483
Tennessee	-	-	-
Region V	11,725	15,189	28,532
Illinois	3,553	6,173	18,474
Indiana	141	13	-
Michigan	3,299	3,028	2,858
Minnesota	850	827	1,747
Ohio	3,882	5,148	5,453
Wisconsin	-	-	-
Region VI	15,117	12,812	13,603
Arkansas	1,345	2,233	2,316
Louisiana	-	-	-
New Mexico	1,499	1,048	920
Oklahoma	-	-	-
Texas	12,273	[illegible]	10,367
Region VII	2,470	4,147	3,767
Iowa	-	-	-
Kansas	-	-	-
Missouri	1,838	2,555	2,412
Nebraska	632	1,592	1,355
Region VIII	4,817	4,858	4,713
Colorado	4,817	4,858	4,713
Montana	-	-	-
North Dakota	-	-	-
South Dakota	-	-	-
Utah	-	-	-
Wyoming	-	-	-
Region IX	884	750	679
Arizona	-	-	-
California	376	249	252
Guam	-	-	-
Hawaii	484	501	427
Nevada	24	---	-
Region X	739	2,134	1,696
Alaska	-	-	-
Idaho	109	146	157
Oregon	256	462	338
Washington	374	1,526	1,201

The decline in numbers served in 1973 is the result of a reporting change and is not a program reduction.

TABLE 6

Number of Women Provided Family Planning Services Under State Programs of Maternal and Child Health, FY 1973, 1972, and 1971

State	1973 Provisional	1972	1971	
United States	1,017,000	1,052,663	763,234	
Alabama	21,227	62,528	50,669	
Alaska	---	---	892	
Arizona	25,369	25,629	11,806	
Arkansas	23,283	19,114	15,066	
California	---	121,074	93,931	
Colorado	7,321	4,761	1,242	
Connecticut	---	-	---	
Delaware	9,223	7,440	5,676	
Dist. Columbia	---	---	---	
Florida	104,348	98,077	67,704	
Georgia	89,307	88,628	75,799	
Guam	---	---	---	
Hawaii	607	390	---	
Idaho	2,757	1,746	920	
Illinois	3,700	6,623	5,997	
Indiana	12,754	10,525	5,127	
Iowa	711	---	---	
Kansas	---	---	8,300	
Kentucky	23,715	49,168	12,170	
Louisiana	---	-	---	
Maine	1,300	12,000	3,900	
Maryland	---	8,693	4,816	
Massachusetts	---	-	---	
Michigan	---	20,374	9,654	
Minnesota	3,170	-	1,300	
Mississippi	32,711	30,156	22,095	
Missouri	41,630	41,421	25,166	
Montana	---	-	1,893	
Nebraska	---	188	---	
Nevada	3,884	2,967	2,726	
New Hampshire	---	-	---	
New Jersey	---	---	---	
New Mexico	4,660	-	3,260	
New York	---	9,646	10,034	
North Carolina	55,089	48,644	35,081	
North Dakota	---	-	549	
Ohio	38,059	76,904	62,944	
Oklahoma	---	35,850	17,645	
Oregon	35,305	28,979	6,275	
Pennsylvania	---	---	---	
Puerto Rico	---	364	---	
Rhode Island	14,618	---	---	
South Carolina	38,399	32,554	---	
South Dakota	1,196	1,093	---	
Tennessee	66,244	98,233	72,486	
Texas	75,354	47,095	32,131	
Utah	4,523	4,219	963	
Vermont	---	-	---	Code:
Virgin Islands	---	---	---	- Zero
Virginia	90,000	39,946	51,528	--- Data
Washington	90	5,720	31,680	not
West Virginia	13,423	9,996	6,496	avail-
Wisconsin	3,791	1,633	-	able
Wyoming	514	265	315	

TABLE 7

Number of Women Provided Family Planning Services
Under State Programs of Maternal and Child Health, FY 1973

Provisional #

State	Total	New This Year	Carried Over From Last Year
Total	1,017,000		
Region I	15,918		
Connecticut	-	-	-
Maine	1,300‡	—	—
Massachusetts	-	-	-
New Hampshire			
Rhode Island	14,618	—	—
Vermont	-	-	-
Region II	10,000		
New Jersey	-	-	-
New York	—	—	—
Puerto Rico	—	—	—
Virgin Islands			
Region III	121,339		
Delaware	9,223	4,740	4,483
Dist. of Columbia			
Maryland			
Pennsylvania			
Virginia	90,000*	23,402*	66,598*
West Virginia	13,423	6,642	6,781
Region IV	440,040		
Alabama	21,227	—	—
Florida	104,348	56,016	48,332
Georgia	98,307	38,245	60,062
Kentucky	23,715	6,149	17,566
Mississippi	32,711	17,696	15,015
North Carolina	55,089	25,578	29,511
South Carolina	38,399	15,339	23,060
Tennessee	66,244	23,324	42,920
Region V	80,848		
Illinois	3,700*	2,300*	1,400*
Indiana	12,754	—	—
Michigan			
Minnesota	3,170		
Ohio	38,059	22,851	15,208
Wisconsin	2,791	1,388	1,403
Region VI	103,797		
Arkansas	23,783	13,170	10,613
Louisiana	—	—	—
New Mexico	4,660	—	—
Oklahoma	—	—	—
Texas	75,354	40,618	34,736
Region VII	42,341		
Iowa	711	—	—
Kansas			
Missouri	41,630	12,047	29,583
Nebraska			
Region VIII	13,554		
Colorado	7,321	—	—
Montana	-	-	-
North Dakota	-	-	-
South Dakota	1,196	—	—
Utah	4,523	2,436	2,087
Wyoming	514	268	246
Region IX	150,060		
Arizona	25,369	12,924	12,445
California			
Guam	-	-	-
Hawaii	607	519	88
Nevada	3,884	2,457	1,427
Region X	38,152		
Alaska			
Idaho	2,757	1,280	1,477
Oregon	35,305	18,288	17,017
Washington	90	76	14

* Estimated from visit
‡ Estimated from expenditure data
# National and Regional Totals include estimates for non-reporting States

TABLE 8

GEOGRAPHIC COVERAGE BY COUNTY

Counties with Organized Family Planning Services		
6-30-72	6-30-73	Change
2,370	2,625	+255

Number of Counties	Type of Organized Family Planning Services Available 6-30-73			
	Facility Within the County	Physician Referral Program Within the County	Facility in Adjacent County	Physician Referral Program in Adjacent County
3,074 1/	1,905	449	230	41

1/ Alaska is considered to be one county.

TABLE 9

GEOGRAPHIC COVERAGE BY REGION
AS OF JUNE 30, 1972 and JUNE 30, 1973

U. S. and Region	Number of Counties	Counties With Organized Services Available*		Change FY 1973	Counties Without Organized Services Available 6-30-73
		6-30-72	6-30-73		
U. S. Total	3,074	2,370	2,625	+255	449
Region:					
I	67	48	64	16	3
II	83	67	83	16	0
III	247	209	232	23	15
IV	736	714	736	22	0
V	523	331	419	88	104
VI	502	415	430	15	72
VII	411	271	313	42	98
VIII	292	172	161	-11	131
IX	93	74	92	18	1
X	120	69	95	26	25

* Includes counties which use service facilities located in adjacent counties.

TABLE 10

GEOGRAPHIC COVERAGE BY REGION AND STATE AS OF JUNE 30, 1972 AND JUNE 30, 1973

Region or State	Number of Counties	Counties With Organized Services Available		Change FY 1973	Counties Without Organized Services Available 6-30-73
		6-30-72	6-30-73		
Region I Total	67	48	64	+16	3
Massachusetts	14	7	12	5	2
Connecticut	8	6	8	2	-
Maine	16	13	15	2	1
Rhode Island	5	5	5	-	-
New Hampshire	10	8	10	2	-
Vermont	14	9	14	5	-
Region II Total	83	67	83	+16	-
New York	62	51	62	11	-
New Jersey	21	16	21	5	-
Puerto Rico	-	-	-	-	-
Virgin Islands	-	-	-	-	-
Region III Total	247	209	232	+23	15
Pennsylvania	67	39	54	15	13
Virginia	98	94	97	3	1
West Virginia	55	49	54	5	1
Maryland	23	23	23	-	-
District of Columbia	1	1	1	-	-
Delaware	3	3	3	-	-
Region IV Total	736	714	736	+22	-
North Carolina	100	94	100	6	-
Florida	67	67	67	-	-
Georgia	159	158	159	1	-
Tennessee	95	95	95	-	-
Alabama	67	67	67	-	-
Kentucky	120	105	120	15	-
Mississippi	82	82	82	-	-
South Carolina	46	46	46	-	-

Region or State	Number of Counties	Counties With Organized Services Available		Change FY 1973	Counties Without Organized Services Available
		6-30-72	6-30-73		6-30-73
Region V Total	523	331	419	+88	104
Ohio	88	69	88	19	-
Illinois	102	37	92	55	10
Michigan	83	77	83	6	-
Indiana	92	43	51	8	41
Minnesota	87	69	66	-3	21
Wisconsin	71	36	39	3	32
Region VI Total	502	415	430	+15	72
Texas	254	182	194	12	60
Louisiana	64	64	64	-	-
Arkansas	75	75	73	-2	2
Oklahoma	77	64	69	5	8
New Mexico	32	30	30	-	2
Region VII Total	411	271	313	+42	98
Missouri	114	77	104	27	10
Iowa	99	63	68	-2	31
Kansas	105	70	68	5	37
Nebraska	93	61	73	12	20
Region VIII Total	292	172	161	-11	131
Colorado	63	44	43	-1	20
South Dakota	67	46	59	+13	8
Utah	29	29	29	-	-
North Dakota	53	26	12	-14	41
Montana	56	16	12	-4	44
Wyoming	24	11	6	-5	18
Region IX Total	93	74	92	+18	1
California	58	53	58	5	-
Arizona	14	12	13	8	1
Nevada	17	5	17	5	-
Hawaii	4	4	4	-	-
Guam	-	-	-	-	-
Region X Total	120	69	95	+26	25
Washington	39	21	34	13	5
Oregon	36	19	27	8	9
Idaho	44	28	33	5	11
Alaska (Legislative Districts)	1	1	1	-	-

In FY 1973, about 400 family planning services projects were supported mainly by project grants authorized under PL 91-572 (Title X of the Public Health Service Act). Sixty-one family planning services project grants received $19 million under SSA Title V. Fifty-eight of these also received funds from other Federal sources. In addition, fifty-seven Maternity and Infant Care (M&I) projects provided family planning services to 115,000 women in FY 1973. The States reported that SSA Title V Maternal and Child Health Formula Grants helped supported family planning services for 1,017,000 individuals during FY 1973. The apparent decline in the number of women served in M&I projects reflects a change in reporting procedures and is not a program reduction.

Progress in extending family planning services geographically continued in FY 1973. By June 30, 1973, some form of organized subsidized family planning services was available to residents in 2,625 of the 3,074 counties in the United States. This was an increase of 255 counties over those reported with services available on June 30, 1972. Of the 2,625 counties with services available, 2,354 counties had facilities or physician referral programs within their boundaries, and 271 had facilities or physician referral programs in adjacent counties. The type of coverage within each county as well as the increase in geographic coverage from June 30, 1972 is indicated in Table 8.

The fact that some services are available to residents of a county does not mean that services are accessible to all low-income women in the area. Many service providers have limited capacity and are not within easy reach of all women in the area. These county statistics are presented to indicate that organized subsidized family planning services now exist in most areas of the country which is a significant improvement from just a few years ago. The percentage of counties considered to have some coverage increased from 77 percent of all counties in FY 1972 to 85 percent in FY 1973. Most counties still without coverage are sparsely settled and have few low-income women. Efforts are continuing to provide some form of service to those counties which do not have services available.

The extent of coverage reported is based on a program review conducted in each Regional Office during the first months of FY 1974. Data for each Region was reviewed by the appropriate Regional Family Planning Program Director and where necessary, adjusted to reconcile with existing Regional information. Tables 9 and 10 show the number of counties with services available as of June 30, 1972, and June 30, 1973, by Region and State.

In 1974, emphasis has been on combining or coordinating existing family planning services grants to achieve full coverage within a State or within designated areas of a State. Continuing efforts are being made to involve all elements of the health services delivery system in the provision of family planning services and to make family planning a basic component of all comprehensive health programs. Projects are being encouraged and assisted to improve their management and accounting practices in order to improve their ability to obtain third-party reimbursements.

Other program activities involved in family planning carried out by BCHS include:

Training
Information and Education
Services Delivery Improvement

Training. In fiscal year 1973, six Regional Training Centers were established for training service provider personnel, bringing the total established to eight with a ninth scheduled for FY 1974. The tenth Region is served by five Statewide training programs.

In addition to the training centers, specialized training in family planning methods was conducted for nurses; training was conducted to prepare individuals to become physicians' assistants in family planning; and a seminar program in contraceptive technology for physicians was established.

Contracts have been approved to teach selected paraprofessionals to become trainers and to develop a family planning training curriculum for medical schools.

Training was conducted in FY 1973 for 3,889 professionals and 1,758 paraprofessionals.

During FY 1974, the Bureau of Community Health Services will conduct a review of the effectiveness of all training programs to determine the FY 1975 training program. Preliminary estimates of manpower needs indicate that there will be an increased need for training paraprofessionals for clinical service jobs and a decreased need for training outreach workers. FY 1974 funding for training was $3,000,000.

In addition to the family planning training cited above nurse training programs conducted under Maternal and Child Health activities included family planning components. BCHS supports long- and short-term training programs for a variety of health professionals in the form of grants and technical consultation. All graduate programs it supports in nursing now offer theoretical content and clinical practice in family planning.

Nurse-midwifery programs have a major component of family planning integrated into both their classroom work and their clinical practice. The following table identifies these programs:

	Program Length	Number of Students Supported by MCH	Degree
University of Mississippi	12 months	10	Certificate
Columbia University	11 months	16	M. S.
Emory University (Grady Hospital)	12-24 weeks	6	None
John Hopkins University	24 months	14	MPH
University of Utah	24 months	6	M. S.
State University of New York	20 weeks (internship)	12	None
University of Illinois	24 months	6	M. S.

In addition to the above, 20 nurses were enrolled in the Mississippi program and 14 at the University of Utah but received no direct financial support from MCH. An example of the training conducted is the Internship Program at the State University of New York which offers its students a means of perfecting basic skills, developing more mature judgment, and broadening and deepening knowledge in clinical nurse-midwifery. Some of them gave high priority to family planning and elected a block experience in the Family Planning Service of Kings County Hospital of Downstate Medical Center. The service provides 98 percent of the postpartum supervision and family planning service at the Kings County Hospital alone.

Interns in the program felt that family planning comprised an important aspect of complete maternity care. Most job requirements include responsibility for this area of care.

The University affiliated Facilities, which offer multi-disciplinary training in mental retardation and are supported by MCH, is offering training in meeting the special needs of the retarded including family planning. Emphasis is on teaching them responsibility for their sexual activity. For example, the Institute for the Study of Mental Retardation and Related Disabilities at the University of Michigan and the Eunice Kennedy Shriver Center for Mental Retardation at the Walter E. Fernald State School in Waltham, Massachusetts, both offer their social work and nursing students background on the rights of retarded adults, as well as specific knowledge of physiology, venereal disease, and contraceptives which can be used to counsel the young retarded adult.

Information and Education. Activities in FY 1974 included a contract for developing prototype family planning and health education materials for members of specific ethnic or cultural minorities--American Indians and Spanish Speaking Americans. In addition, workshops were supported to identify family planning and family life education needs of mentally retarded individuals and to provide technical assistance to service providers for design and operation of information and education activities. A model fertility education program for adolescents was established in one public school system and Statewide conferences were held for educators, health officials, and community leaders on adolescent sexuality. A bi-monthly periodical containing abstracts of family planning articles, reports, and speeches was published and a multi-media communications campaign was launched.

Plans for fiscal year 1975 include continuation of programs for adolescents, mentally retarded individuals, and ethnic and cultural minorities. A program directed toward teenage fathers and prospective fathers will be initiated, and a model family planning information and education program for use in hospital outpatient clinics will be developed. The specific needs for information and education materials in family planning will also be assessed.

Services Delivery Improvement. Services Delivery Improvement is directed towards increasing knowledge to improve operation of the family planning service providers.

In fiscal year 1974, $2.5 million was obligated for Services Delivery Improvement. Eight research projects were supported to explore and evaluate techniques for serving the underserved segments of the population including rural residents, adolescents, handicapped individuals, and low-income workers.

Five contracts were awarded in the areas of management information and planning. Special studies include the design and development of an experimental operations model and the development of materials for family planning management training in the area of consumer relations.

Plans for fiscal year 1975 include demonstration projects for delivery of services to hard-to-reach groups, disabled individuals, and program dropouts; development of a Statewide model to obtain third-party reimbursements; and an investigation of the possibility of developing a training curriculum for natural family planning methods. The purpose of the latter is to improve the capability of Federally funded family planning clinics to instruct patients who wish to choose natural family planning methods for individual, ethical or religious reasons.

The Federal Health Programs Service provides comprehensive family planning services to eligible beneficiaries through its system of hospitals and outpatient clinics. Family planning services may include the prescription and provision of pharmaceutical preparations including oral contraceptives and mechanical devices, surgical sterilization, and counseling.

All postpartum patients are offered family planning information and services as part of the follow-up medical care at the Public Health Service Hospitals which have obstetrical services (Staten Island and New Orleans). All USPHS hospitals and clinics provide family planning services upon request. There were an estimated 15,500 family planning services visits in fiscal year 1971, 18,400 visits in fiscal year 1972, and 12,200 visits in fiscal year 1973. Community oriented family planning services are provided at the Boston Public Health Service Hospital through an agreement with the Massachusetts State Department of Health and St. Elizabeth's Hospital. The number of family planning visits declined in FY 1973 because reduced staffing required a cutback in discretionary services.

The Division of Federal Employee Health, through the health unit operations, provides the following family planning education and counseling services upon request:

1. Family planning literature.
2. Access to a physician and/or nurse to discuss family planning.
3. Referral to public and private health care facilities for family planning services.

The Indian Health Service has been active in the field of family planning since fiscal year 1965. Since that time through June 30, 1973, family planning services have been provided to 54,300 women. In fiscal year 1973, there were 39,000 medical visits by 22,300 Indian and Alaskan native women for family planning services. In FY 1973, the number of Indian women 15-44 years of age was estimated at 95,700.

Other Family Planning Activities in the Bureau of Community Health

Related activities in the Bureau of Community Health Services are directed toward improving the health and welfare of the family as a whole. Over 150 community and family health centers foster the delivery of family oriented health services, including family planning services, to areas with a high concentration of urban and rural poor. Health maintenance organizations, also family oriented, enable families to receive a range of services in exchange for receipt of prepaid premiums to an HMO. A special population group, migrant and seasonal farmworkers and their families, is supported through 103 migrant health projects, some of which provide family planning services. The National Health Service Corps places teams of health professionals in medically underserved areas. Family planning services are among the services provided to persons residing in these areas. Finally, under Formula Grants to States for Public Health Services, authorized under Section 314(d) of the PHS Act, States receive funds for meeting special health needs of people or for launching new programs which result from their own planning. Many States use the flexibility of this funding mechanism to expand their services into such areas as family planning.

Health Resources Administration

The National Center for Health Statistics (NCHS) collects and publishes natality, marriage and divorce, and mortality statistics. It also engages in research on the dynamics of population change and examines some of the social and economic factors associated with change. NCHS conducts annual vital records surveys. NCHS has just completed the first phase of a continuing survey of family growth in the United States. This survey is designed to collect data on factors affecting the birth rate, family planning, and infant and maternal health. This was conducted through the use of the field operations of a private survey organization with periodic interviewing of a representative sample of ever-married women in childbearing ages. Data from this survey will be released in early 1975.

NCHS and the Research Triangle Institute in North Carolina have collaborated in the development of a computer model intended to simulate the dynamics of population growth. A manual is being prepared to enable others, within this country and abroad, to apply the model to their own population structure and problems.

NCHS is responsible for operating a uniform national family planning services reporting system. This reporting system has been developed in two steps. NCHS worked with the National Center for Family Planning Services, Maternal and Child Health Service, the Office of Economic Opportunity, and Planned Parenthood-World Population, and other governmental and private family planning groups to initiate a provisional family planning reporting system. This provisional system provided data on the utilization of family planning services which were financed at least in part by Federal funds, and for which there was an immediate program need for data.

Based on the experience gained from the operation of this provisional system, NCHS developed the National Reporting System for Family Planning Services (NRSFPS) for use by all federally supported family planning programs, clinics, and service points, and by other agencies wishing to participate in the reporting system. This system now provides monthly, quarterly, and annual reports essential for the efficient and effective development, operation, and evaluation of family planning programs throughout the Nation.

Center [illegible] Disease Control

The Center for Disease Control (CDC) provides assistance to state, local, and international health agencies in the evaluation of family planning programs. Epidemic Intelligence Service (EIS) Officers and Public Health Advisors (PHA) are assigned in Georgia, Maryland, New York, and California to develop and maintain data processing systems for family planning service statistics, to analyze contraceptive use and effectiveness, and to conduct special studies based on these analyses. In addition to these continuing assignments, short term assistance is given to family planning programs for improving program management, designing service statistics systems, and evaluating family planning program performance.

As state abortion laws became less restrictive in 1967, data concerning abortion mortality and the practice of legal abortion become increasingly important. CDC maintains surveillance of abortion practice and abortion deaths through a nationwide reporting system. In 1969 approximately 22,000 legal induced abortions were reported to CDC on a voluntary basis by state and local health departments. The following year more than 180,000 abortions were reported; in 1971 that number increased to 586,760. Since 1972, New York City, Dallas, Philadelphia, Buffalo, Chicago, Portland (Oregon), and the states of New York, Arkansas, and Kansas were assisted in assessing abortion-related health problems and in determining the measures necessary to prevent them. From the mid-1950's to the mid-1960's abortion mortality did not decline even though other causes of maternal death decreased substantially. Provisional statistics indicate that abortion mortality is now decreasing. In 1969, 132 abortion-related deaths were reported. In 1970 there were 140 such deaths and, in 1971, 120 occurred. A marked decrease occurred in 1972 when 71 deaths were reported and provisional data for 1973 indicate that the number will be even smaller. As many women seek legal abortions in places other than their home state, federal and state cooperation is necessary if the favorable trend in abortion mortality is to continue.

Epidemiologic field investigations of medical consequences of drugs, devices, and techniques employed in family planning programs are being conducted. Morbidity and mortality associated with the use of the intrauterine device (IUD) is one of the studies being conducted. Questionnaires were sent to physicians considered most likely to have inserted IUDs or to have examined women with IUD complications. Preliminary data indicate that more than 3,900 hospitalizations and 5 deaths occurred during the first 6 months of 1973.

Alcohol, Drug Abuse and Mental Health Administration

The National Institute of Mental Health (NIMH) recognizes the special contribution that can be made by mental health personnel in the area of family planning. The Institute is involved in this area of concern through its research, training, and service programs.

The Institute views family structure as it relates to the larger social structure and to such social structure variables as occupation, social class, economic status, and life style. Since the Institute recognizes that programs of family planning must be modified to fit the facts of a diverse society, it seeks to determine these facts as they relate to mental health issues.

The Institute is interested in the implications of family size for the physical and mental health of family members. It is also interested in child spacing and its effect on family functioning and on the personality development of children. It seeks to determine the strengths and weaknesses of differing family forms and sizes; the effects of abortion and sterilization; the role of adoption; and the implications of working mothers, increased family incomes, and day-care centers on the family planning process.

Thus, the Institute seeks to determine the kinds of mental health services needed by families of differing sizes and forms, the adequacy of one-parent homes in providing crisis support to individual members, and the correlations between family size and the emotional characteristics of family members. Biometric data, for example, indicate that the heads of families with one child - both parents present - have lower admission rates to psychiatric facilities than the heads of those families which contain several children; yet, the children of one-child families - both parents present - have higher rates of hospitalization than children in families where siblings are present. Data of this nature have important implications for the Institute's contribution to family planning services.

The Institute encourages and supports family planning services provided through community mental health facilities. In its training and educational support programs, NIMH stimulates family planning programs in the training of public health nurses, teachers, social workers, and others involved in sex and health education. Through the Center for Studies of Child and Family Mental Health, the Institute encourages research in mental health and the behavioral aspects of family life. Examples of NIMH-supported research grant projects which deal directly with family planning are:

1) Examining the effects of siblings - number, relative ages and sexes - on a child's intellectual ability, social behavior, and personality characteristics.

2) Studying the motives and conflicts which influence childbearing and family planning; relating these factors to the course and outcome of pregnancies and postpartum family relationships.

3) Exploring the philosophies of family formation held by "trans-racial adoptive families;" the social and emotional characteristics of these adoptive parents.

4) Developing scales for appraising sexual attitudes and use of the scales in assessing in-service sex education programs for teachers.

5) Investigating the role resolutions of young mothers to determine the factors involved in assumption of an adult status vs. returning to the world of youth.

6) Evaluating a program of intensive aftercare with discharged psychotic mothers of young children and conducting a survey of family planning knowledge, attitudes, and practices of the women.

7) Studying a variety of social policy issues, including family planning, for which marital and family variables are important.

In addition, a large group of research grant projects bear indirectly on family planning: communication and decision-making within families; patterns of family life; motivation; sex education; and population characteristics. The Center for Studies of Child and Family Mental Health investigates the structure of the American family; i.e., what factors contribute to breakdown in the family structure in the affluent suburban household; problems of role identification as a father for the third generation AFDC recipients. The NIMH Division of Intramural Research carries out projects on family formation, child spacing, and animal studies of population density.

National Institutes of Health

Summary of Programs Related to Population Research and Family Planning

The research programs of the Department in the population sciences are directed by the National Institute of Child Health and Human Development. Section 444 of the Public Health Service Act authorizes the Institute to conduct and support research and training relating to maternal health, child health, and human development, including research and research training in the special health problems and requirements of mothers and children and in the basic sciences relating to the processes of human growth and development, including prenatal development.

Expenditures by the Institute in fiscal year 1973 for population research were $39.8 million. They are projected to be $51.4 million for fiscal year 1974 which includes approximately $6.5 million release of FY 1973 impounded funds.

Other components of the National Institutes of Health provided $5.8 million in fiscal year 1973 to support a variety of extramural activities with important implications for population research. Research in reproductive endocrinology supported by the National Institute of Arthritis and Metabolic Diseases totalled approximately $2.4 million in fiscal year 1973. These studies provide basic information essential in the development of new methods for controlling reproductive processes. The National Cancer Institute's interests in reproductive endocrinology and other reproductive functions are relevant to understanding normal function and fertility control. In fiscal year 1973, $0.6 million was spent to support these studies.

The National Heart and Lung Institute awarded $0.4 million for studies of the effects of estrogens, progestogens, and steroid contraceptives on blood clotting mechanisms and the physiology of circulation. Several studies in reproductive neuroendocrinology and genetic aspects of reproduction were supported by the National Institute of Neurological Diseases and Stroke and the National Institute of General Medical Sciences, respectively. Support for population research in these two Institutes totalled about $0.2 million in fiscal year 1973. The Division of Research Resources administers approximately $2.3 million in general research support relevant to the population field.

National Institute of Child Health and Human Development

The National Institute of Child Health and Human Development (NICHD) and its Center for Population Research (CPR), have the primary responsibility for the Federal effort in population research.

This report describes research on the development of new means of fertility regulation, the evaluation of contraceptive methods currently in use, and the analysis of social and behavioral factors in population growth, change and distribution. It also discusses the NICHD effort in fundamental research in reproductive biology and the social sciences, upon which advances in contraceptive development and the solution to problems associated with population dynamics are dependent. In addition, it describes the Institute's program to support institutions, develop scientific manpower, and facilitate the coordination of Federal population research programs and the communication of research information in the population sciences. The names in parentheses indicate NICHD grantees, contractors, and intramural scientists whose findings are mentioned.

A. Biomedical Research

1. Contraceptive Development

The year 1973 represented the consolidation of an expanding program of research aimed at new approaches to fertility regulation. Two of the three areas of endeavor, drug development and device development, offer the greatest promise of early tangible results. These areas plus the third, directed fundamental research in reproductive biology, represent efforts to balance pragmatic approaches to fertility regulation and the need for expanding the basic knowledge of reproductive processes to find new, safe and efficacious contraceptives for women, and to develop acceptable and effective contraceptives for men.

Drug Development

Drug Synthesis Program. The goals of this program are: to develop for women new and efficiacious chemical contraceptives that will not have undesirable side effects; and, equally important, to develop safe, effective contraceptives that men will find acceptable.

A promising new drug, which is a modification of the female sex hormone (estrogen), has been shown to have high antifertility activity. This result was obtained in the rat (Tanabe) and the drug is now being tested in other species including the monkey.

Synthesis of compounds related to prostaglandins seeks to separate their antifertility activity from undesired side effects of increased gastrointestinal motility (Fried). Some of these new compounds tested in the hamster show some separation of these two activities.

Several laboratories have undertaken the synthesis of compounds which act as inhibitors of LRF (luteinizing hormone-releasing factor) which, if effective could act as contraceptives by blocking the action of the hormone responsible for ovulation. Many such analogs have been synthesized and two of them have proven to be potent inhibitors of LRF action (Schally).

Biological Drug Testing Facility. This testing facility, established in 1972 at the Mason Research Institute, Worcester, Massachusetts, has effectively screened compounds from the synthetic program as well as from private and public laboratories (Rosenkrantz). Procedures have been developed to safeguard proprietary interests in both chemical compounds and mechanical devices. The facility has done a wide range of antifertility and endocrine testing, and it has increased the efficiency of the synthetic program through a rapid feedback of biological data to Institute staff.

New Uses of Existing Drugs. Concern over the use in the human of the artificial estrogen DES (diethylstilbestrol) as a postcoital contraceptive agent has led to the initiation of clinical studies on the safety and efficacy of other synthetic estrogens as well as natural estrogens of biologic origins (Bard, Hanson, and Hale). The aim of these studies is to determine whether these estrogens already on the market are safe.

Data from the testing of drugs as male contraceptive agents indicate that sperm production in the human can be drastically reduced through daily oral administration of a weak androgen (male hormone) combined with a once-a-month injection of a potent androgen (Paulsen). Acceptability of the method is good with a dropout rate of less than 10% and no reported effects on libido.

Device and Systems Development

Drug Delivery Systems. Properly devised delivery systems would eliminate the need for daily drug ingestion, lower the overall dosage required and might also make possible the delivery of the drug directly to the organ where its action is desired. In FY 1973 the Institute expanded its program of drug delivery systems, emphasizing implantable devices of a synthetic polymer matrix into which a drug is incorporated. These devices can be designed to release a drug at a predetermined rate and are removed after the drug is completely absorbed. A number of new studies involve biodegradable materials, e.g., microcapsules containing the hormone progesterone can be injected with an ordinary syringe into cervical or muscle tissue to provide relatively constant drug release over 6-12 months (Nuwayser). The polymer itself is digested by the tissue and is subsequently eliminated from the body. Biodegradable polymers capable of releasing a variety of antifertility drugs are being prepared (Wise, Wall, Sidman).

An intrauterine device (IUD) is being developed to release the female hormones, estriol, which has been shown to have a high antifertility activity in rodents (Dmowski). Another delivery system under development involves drug-loaded microcapsules (Gardner) which can be placed in the vagina; they move into the uterine cavity in a fashion similar to the movement of sperm but do not continue up the tubes (oviducts).

Devices. A new type of an intrauterine device under study (Kitrilakis) consists of reinforced synthetic silastic rubber in the form of a pouch which, after insertion, is expanded by fluid pressure and takes on the configuration of the uterine cavity itself. It appears to be tolerated better than the presently available IUDs and has a low expulsion rate.

An instrument to visualize the female reproductive tract now has been tested in baboons under operating room conditions (Brueschke). It has also been used successfully to insert plugs to close the tubes which carry eggs from the ovary to the uterus. The program calls for preliminary use of this steerable instrument in women scheduled for hysterectomy. Such an instrument, which allows the surgeon to see the inside of the uterine cavity in a safe manner, is a first step in the development of new procedures for fertility regulation.

Development and testing of devices intended for the achievement of easily reversible vasectomy has resulted in major advances (Brueschke, Freund, Nuwayser). Some devices have been in laboratory animals more than 12 months and have been found to be effective. Preliminary data indicate that animals implanted with devices in the open position are fertile. The problem of the adhesion of the devices to body tissues has been resolved.

The drug and device development programs have moved ahead to the point of advanced laboratory and human testing. This multifaceted approach is required in order to make various fertility regulating approaches available to wide population segments.

Directed Fundamental Research

Several important observations have been made during the past year in the area of prostaglandin research which involve the possible role of these compounds in human ovulation, uterine contraction and the dissolution of the corpus luteum, a structure of the ovary necessary for early pregnancy maintenance.

Ovulation. One of the most badly needed measures in primate reproductive physiology is the detection of the precise time of ovulation. This information is essential for the development of new and reliable methods of fertility regulation associated with the "rhythm method." Several studies in this general area (Stegall, Ko, Krotoszynski) are based on the development of optical, mechanical and chemical detectors.

Investigations are being made of the unexpected finding that the brain hormone, thyrotropin releasing factor, TRF (which regulates the thyroid gland), can block ovulation in the baboon when administered either around the time of ovulation or throughout the cycle (Hagino, Cole). The menstrual pattern in these animals remained normal.

Male Reproductive Tract. Significant new knowledge of the basic physiology of the male reproductive tract is providing new ideas on possible ways of limiting male fertility without interfering with the other functions of the testis or with libido. After the sperm leave the testis and before they are ejaculated, they undergo a process of maturation, i.e., they become motile and acquire the enzymatic ability to fertilize or penetrate the egg. This occurs while the sperm are passing through the elongated ducts (epididymedes) of the male reproductive tract. We now know that there is an unusual mechanism in the epididymis which concentrates the hormones produced by the testis so that their levels are many times higher than they are in peripheral blood (Amann, Fawcett). In addition, measurement of the various androgens in the epididymis has shown that testosterone, the principal testicular androgen in peripheral blood of men, is not the androgen in highest concentration in the epididymis. After castration, the epididymal function of white rats cannot be restored by hormone injection (Leathem). These data suggest the possibility of male fertility regulation through drugs acting specifically on this structure.

2. Fundamental Biomedical Research

Increased knowledge of basic reproductive processes is needed for the development and improvement of contraceptive agents. The chain of processes involving the steroid hormones is particularly crucial for reproduction.

The pituitary, the so-called master gland, secretes large complex hormones (gonadotropins) which in turn act on the gonads (ovary or testis) to make them produce their respective sex steroid hormones, the estrogens and androgens. These hormones of the gonads then act back upon the hypothalamus and the pituitary to modify its secretion. The pituitary itself is controlled by a part of the central nervous system called the hypothalamus which secretes simple hormones (gonadotropin-releasing hormones). Signals from higher brain centers and sensory input from the environment influence the secretion of the hypothalamus. The whole system (the brain-hypothalamus-pituitary-gonads) can be regarded as a circuit, each part influencing the other so that an input at any one point will set up a chain of events. Our particular interest in this circuit is in its production of the ovum (egg) and sperm for fertilization and conception (the taking-in or implanting of the fertilized ovum into the uterus). Research is being conducted at all levels of the reproductive processes as modification or interruption of hormonal signals anywhere in the circuit could result in the prevention of conception.

Work was recently completed on the structure of two very important human gonadotropins: the protein portion of human luteinizing hormone; chorionic gonadotrophin (from the placenta) (Bahl, Closet, Popkoff). Gonadotropins act upon the gonads by attaching or binding themselves to receptors associated with the cell membranes of the ovary or testis; one can regard this as a simplified lock and key arrangement. Determination of the structure of these so-called binding or receptor molecules of the cells of target organs is being vigorously studied (Catt). Since both of these hormones are required for human pregnancy, knowledge of interactions with their respective receptors could lead to new contraceptive measures.

The growth of the ovarian cell or follicle which will produce the ovum is highly dependent upon an increase in the cell wall of the number of receptor molecules for gonadotropin (Channing). Young ovarian cells cannot respond to stimulation by gonadotropin to produce eggs because they do not have enough molecules for binding the hormone. If the number of receptor molecules in the growing follicle could be restricted, the cell would degenerate. This opens an interesting new lead for contraception.

Several important steps have been identified in the mechanism of action of progesterone (O'Malley, Segal) and other sex steroids. Progesterone is often referred to as the hormone of pregnancy because its action on the uterus is required for the maintenance of pregnancy in the human as well as in other species. New knowledge in this area could form the basis for contraception through interdiction of progesterone action.

The local circulation of a hormone within its target tissue is important for its action. The testis now has been shown to have a concentrating mechanism for its androgenic hormone, testosterone, so that the local concentration is much higher than that in the peripheral blood stream. These facts have led to the proposal for an improved male contraceptive (Steinberger). Gonadotropin secretion can be inhibited by normal physiological amounts of testosterone; inhibition of gonadotropin should then decrease the high intratesticular concentration of testosterone needed for sperm production. The use of exogenously administered testosterone for male contraception would maintain libido and not have the undesirable effects of other sperm-suppressing agents.

3. Contraceptive Evaluation

Current ongoing programs are evaluating the medical effects of oral contraceptives and of vasectomy.

Oral Contraceptives

Surveillance of a large population of women has revealed an increase in the prevalence of hypertension (high blood pressure) from 1.2 per thousand among women not using oral contraceptives to 6.8 per thousand women using oral contraceptives (Ramcharan). An increase in asymptomatic urinary tract infections was also observed among oral contraceptive users (Takahashi). Preliminary analysis of two case-control studies shows no relationship between breast cancer and the use of oral contraceptives (White, Paffenbarger).

The most widely documented adverse effect of oral contraceptives concerns the increased risks of thrombosis (blood clot formation). It was not previously known whether brain or cerebral thrombosis (stroke) also occurred. Relationships of dose, formulation and pre-disposing factors also remained unknown. Current studies show that oral contraceptives do increase the risk of stroke (Heyman). The frequency of such complications can be reduced by lowering the dosage of the drugs. Hypertension, regular cigarette smoking and a history of migraine increase the risk of stroke when combined with current use of oral contraceptives.

Analysis of the data on chromosome breakage in cultured blood cells from women taking oral contraceptives and control subjects has demonstrated a small but significant increase in breakage in cells from oral contraceptive users (Littlefield). Broken chromosomes are seen in 7.1% of cells from oral contraceptive users who have never been pregnant, as compared with 5.3% of cells from women who have never used the pill or been pregnant. Women who have previously been pregnant also show more chromosome breakage than those who have not been pregnant.

Oral contraceptive agents appear to alter the requirements for several vitamins and minerals. Several projects are underway to assess the scope and significance of these findings.

An important observation was made regarding the effects of vitamin B_6 (pyridoxine) on users of oral contraceptives (Rose, Brown). For those women users who had abnormal glucose tolerance (decreased ability to maintain normal blood sugar level) suggestive of diabetes, and who also had biochemical evidence of vitamin B_6 deficiency, administration of vitamin B_6 was found to return the glucose tolerance to normal levels.

Studies are continuing on the metabolism and effects of oral contraceptives in various animal species which may be useful in predicting effects of these drugs in man.

Medical Effects of Vasectomy

Progress has been made in defining the antigens (substances which produce body defense reactions) of sperm which may initiate an immune reaction after vasectomy. One study indicates that antigens on the surface of mouse sperm are under genetic control and that genes for a number of different antigens exist in normal mouse population (Bennett), while another has discovered an antigen in human sperm and the occurrence of antibodies (products of the body's defense mechanism in response to antigens) to this antigen in the blood of some infertile men (Rumke). Another project is concerned with the effects of vasectomy on the functioning of the male reproductive system in laboratory animals (Gillenwatter and Howards).

In a comprehensive two-year study of hormone levels in the blood of men before and after vasectomy, thus far no significant changes in the levels of the tested hormones have been detected (Smith). If these preliminary results are confirmed, one area of concern about possible adverse effects of vasectomy will have been eliminated.

Program Development

A new program will be launched in FY 74 to evaluate the effects of various forms of contraception on the frequency of birth defects.

B. Behavioral Sciences Research

The goals of the NICHD behavioral sciences program of research in population continue to be (1) to ascertain the social, psychological, and economic determinants of fertility in the United States and (2) to develop an increased understanding of the consequences of population growth and change so that public policy may be guided by adequate information.

Fertility in the United States

The National Fertility Study of 1970 has shown that low income couples, probably through the efforts of family planning programs, have almost caught up to the level of contraceptive usage of high income couples (Westoff, Ryder and Bumpass).

Despite the greater effectiveness of contraceptive practice among married couples, teenagers remain a highly vulnerable group. A national sample of teenage females indicates that the likelihood that a never-married teenage female has experienced coitus rises from 14 percent at age 15 years to 27 percent at age 17, and to 46 percent at age 19 years (Kantner). Less than one-half of those sexually experienced used any method of contraception for the most recent exposure to the risk of conception and less than one-fifth have always utilized a means of contraception.

The frequency of premarital intercourse among teenagers and their non-use of contraception has led to high rates of illegitimacy. In California, 81 percent of the births to mothers under 15, and 40 percent to those 15-17, are illegitimate (Davis). Teenage women whose first child was born or conceived before marriage tend to bear more second children within three years of marriage than do older brides. When first enacted, legalization of abortion in California reduced the number of illegitimate births, but in the most recent year studied the rate of illegitimacy leveled off and actually rose for white women under 20.

A study of fertility differentials by counties for 1960 indicates that rural fertility was higher than urban, that American Indians had the highest fertility of all major ethnic groups, followed by Southern rural blacks, and that the highest white fertility was found in Spanish-American areas (Tarver).

While the availability of oral contraception played a part in the decline in marital fertility in the 1960s in rural areas, the reduction of fertility since that date is due to improvement of economic status (Easterlin).

In a study of the values individuals place upon children, six were isolated as influencing the preferred number of children: economic concerns; parental attention toward each child; companionship of siblings; mental strains and worries of parenthood; physical energy required for parenthood; and over-population concerns. The findings indicate that those values which deter people from having large families are more significant than those which encourage many children (Terhune).

The relationship between the status of women, especially their employment status, and their fertility is receiving attention. Early labor force participation, type of work, career aspirations, social and psychological pressures, career selection, and job status are factors which appear to affect fertility decisions concerning the number and spacing of children (Mason, Scanzoni, Broverman, Presser, Hoffman, Pendleton, Treiman).

The Institute is also giving attention to the effect upon the birthrate of family planning programs, the reaction of ethnic groups to such programs, and the contraceptive effectiveness within such programs (Udry and Jaffe). Another project indicates that strong identification with the black subculture underlies negative and ambivalent attitudes toward birth control and family planning programs operated by non-blacks, but reveals strong support for family planning and sex education in public schools (Darity).

Trends in Fertility and Factors Contributing to Fertility Decline

In a major study being conducted on the social conditions associated with fertility declines in Europe during the past two centuries, three broad conditions have been found to be necessary for a decline: (1) the acceptance of rationality in determining marital fertility; (2) perception of the advantages to be gained from reduced fertility; and (3) a knowledge of effective contraceptive techniques. These conditions occurred in European communities with relatively little modernization (Coale).

Other studies of developing countries emphasize the role of various aspects of modernization such as urbanization, industrialization, and education in reducing fertility (Kirk). Participation of women in the labor force and higher levels of literacy and education (Goldstein), later age at marriage (Freedman), and high aspirations for one's self and one's children (Zimmer), also bring about declines in fertility. On the other hand, in Indonesia the perception that children can do chores at relatively young ages that free the mother to engage in economic activity tends to keep fertility high (Nag).

Migration and Distribution of Population Growth

Migration is one of the chief means by which populations adjust to social and economic change, with the highest migration rates being among young adults (Long). Migration is usually in response to employment opportunities (El Mckadem), with college-educated men tending to move more frequently than the non-college-educated. The proportion of persons changing residence at all educational levels has increased markedly in the 20-year period between 1935-1940 and 1955-1960. Changes in husband's occupation or place of work is the principal reason for moving. The average white American stabilizes his place of residence in his early forties but the average black does not.

A study of migrants from Eastern Kentucky to Cincinnati indicates that migrants generally increase their income and the community derives far more benefits from the migrants than they cost the city (Anschel). Many of the successful migrants would like to return to their homes at lower wages, but are deterred because the communities from which they come cannot provide even the minimum necessary inducements for returning.

Consequences of Population Growth

One major study of the consequences of population change seeks to analyze those components of the Gross National Product (frequently used as an index of economic well being) which offset disadvantages of population growth (pollution, etc.) and, therefore, represent diseconomies (Singer). An early finding of this study is that while GNP increases more rapidly with more rapid population growth, per capita GNP rises more rapidly when population grows more slowly.

Studies are being undertaken to estimate the major effects of the economy, the resource base, and the environment of a number of alternative demographic developments, both nationally and regionally, that may occur during the next 30-50 years. One study will estimate what the results would be for the economy and the environment under alternative demographic conditions (Ridker). The interrelationship between demographic change and employment growth in metropolitan areas, where 70% of the U.S. population lives, will be examined (Bergsman). The theoretical and policy issues related to the consequences of metropolitan population stability or decline will also be studied (Rust).

An additional consequence of population growth is measurable in terms of the effect of family size and childspacing upon both parents and children. A critical review of the existing literature pertaining to the actual and expected consequences of family upon both parents and children is being prepared (Terhune). Research is being carried out on the effects of birth order, sex of infant, and socio-economic status of mother-child-interaction (Lewis). Another study will analyze data collected to evaluate the influence of family size and birth order on school and career achievement and fertility-related behavior, i.e., age at marriage, size of family, birth spacing, etc. (Claudy).

C. Institutional Development

Population Research Centers and Program Projects

In addition to the usual project grants and contracts, NICHD supports fundamental biomedical and behavioral population research conducted in Population Research Centers and Program Projects. Center Awards provide for funding of facilities and services required for improvement of the quality and productivity of ongoing programs. Implicit in such Awards are long term commitments of support contingent upon maintenance of high quality research. Population Research Center

Awards have been made to the following ten institutions for the studies noted: 1. Vanderbilt University - reproductive hormone actions and their molecular controls; 2. The University of Texas at Austin - population dynamics of minority groups; 3. Population Council at The Rockefeller University - fertility regulation and the antecedents and consequences of fertility; 4. University of Wisconsin - demography and human ecology; 5. University of Chicago - reproductive biology and population genetics; 6. Harvard University - reproductive biology and human reproduction; 7. Johns Hopkins University - fertility in teenage women, family planning services, and fertility regulation; 8. Baylor Medical College - molecular biology of reproductive processes; 9. University of North Carolina - behavioral-social population problems; 10. Columbia University - research by the International Institute for the Study of Human Reproduction.

Program Project Grants are awarded to institutions for the support of multi-disciplinary research programs, consisting of at least three interrelated projects. Six Program Projects are supported at these institutions for the studies indicated: 1. Columbia University - reproductive endocrinology relevant to problems of human reproduction; 2. The University of Michigan - gonadotropic and steroid hormones in a variety of species, and the development of methods of analysis; 3. The Northwestern University Medical School - molecular, cellular and tissue mechanisms operative in the action of hormones upon target cells and tissues; 4. The Oregon Regional Primate Research Center - factors which control the events culminating in fertilization in nonhuman primates; 5. The University of Pennsylvania School of Medicine - biochemical, biological, and morphological events in the early processes of reproduction and development prior to implantation; 6. The University of Texas at Austin - control mechanisms at molecular to organismic levels.

Manpower Development

Although the NICHD training program is being replaced by a fellowship program, the Institute continues to support those trainees, fellows, research career and research career development awardees who received firm commitments for funding before January 29, 1973.

D. Coordination and Communication

The responsibility for coordinating Federal population research programs and communicating research information in the population sciences is accomplished through the following mechanisms:

Interagency Committee on Population Research

The coordination of population research activities on the part of the various Federal agencies continues to be carried out through the Interagency Committee on Population Research (ICPR). An important function of this Committee is to facilitate the exchange of information and ideas and coordinate the efforts of the Federal Government concerned with research related to human population problems. The Committee has representatives from 20 Federal agencies and is chaired by the Director of NICHD's Center for Population Research.

Inventory of Federal Population Research

The ICPR issued its Inventory of Federal Population Research -- Fiscal Year 1972, the fourth of such reports updated annually. This Inventory reports that Federal agencies in fiscal year 1972 supported about $61 million in population research, an increase of one-third over the previous year. An additional $28 million was invested in the generation of statistical data directly relevant to population research. A total of 767 projects were sponsored by Federal agencies in FY 1972, up by almost 100 from the previous year. HEW, with 84 percent of the projects and 71 percent of the total expenditures, heads the list of the Federal agencies which support substantive research in population.

Analysis of Federal Population Research

Another significant product of the ICPR is the Analysis of Federal Population Research -- Fiscal Year 1972. This report, prepared annually by the Committee contains a summary and analysis of current Federally supported population research with recommendations for needed research to meet the gaps in knowledge which have been identified, based on the projects reported for the Inventory.

Population Sciences: Index of Biomedical Research

The communication of population research information is being facilitated through the publication of Population Sciences: Index of Biomedical Research. Approval was recently received by NICHD to publish the journal on a monthly basis, and periodic publication is underway. This bibliographic citation journal provides a useful resource to those concerned with the progress and results of biomedical research in the population field. It is produced with the assistance of the National Library of Medicine and is based on the information contained in the Library's Medical Literature Analysis and Retrieval System (MEDLARS).

Population Research Monographs

NICHD is initiating another important means of communication through its occasional monographs in population research. The monographs will provide a review and evaluation of the state-of-the-art in specialized areas of the biomedical or social sciences aspects of population research. The books will usually contain an evaluative review of the field, annotated citations to the scientific literature, and an analysis of the next steps for achieving progress with regard to meeting research gaps.

Publications of Workshops and Conferences

A large number of publications have resulted from the proceedings and summaries of NICHD conferences and workshops in the population sciences. These scientific journal articles and books constitute a valuable addition to the population research literature.

IV. SOCIAL AND REHABILITATION SERVICE

Summary of Programs Related to Family Planning

Community Services Administration

Family Planning services are included in the Social Services Program authorized by Titles I, IV, VI, X, XI, XIV, and XVI of the Social Security Act. Administration of these programs is in the Community Services Administration.

Individuals eligible for family planning are recipients or potential recipients of public assistance under Aid to Families with Dependent Children, Aid to the Aged, Blind and Disabled and Supplemental Security Income.

Family Planning services include the provision of information, personal counseling, medical services, payment for medical services, referral for medical care, follow-up of medical referrals, provision for transportation and child care arrangements so that parents may obtain medical care, and the development of medical resources when none exist.

The 1972 Amendments to the Social Security Act, P.L. 92-603, make the informing of the availability and the provision of family planning services mandatory to all present, former, or likely recipients of AFDC who are of child-bearing age and impose a penalty of one percent per annum on the Federal share of AFDC funds on States which failed to provide these services in the previous year to eligible persons desiring them. In addition, the Act increases the Federal share of matching for family planning services under Social Services from 75 percent to 90 percent. The Act expands the universe of persons to whom family planning services must be offered since it includes applicants for, as well as recipients of, public assistance and adds a statement on sexually active minors.

Expenditures of Federal funds for family planning under this program is expected to reach $64,460,000 during FY 1975. The rate of growth of about 10% per year in expenditures is expected to decline as States reach their maximum allocation for services under the $2,500,000,000 limitation on social services. Family Planning activities under this program in these States will move toward a program of Information and Referral with the medical aspects of family planning financed through Title XIX medical services. The increase in recipients will continue to climb rapidly but at a lower unit cost as the medical costs associated with family planning are switched to the Medicaid program.

Medical Services Administration

The Social Security Act of 1965 (P. L. 89-97--approved July 5, 1965) added Title XIX, "Grants to States for Medical Assistance" to the Social Security Act. Under the Federal-State medical assistance program which it established, known as Medicaid, States participating in the program were required to provide medical assistance to all recipients of cash assistance. At State option, they could also finance medical care for the medically needy, i.e., those persons who would otherwise be eligible for cash assistance except that the level of their income is sufficient to sustain themselves, but too low to provide necessary medical care. In addition, States may opt to provide coverage to any poor child under 21.

Under the original legislation, inclusion of family planning services was a State option. However, P. L. 92-603, passed in October 1972 made coverage of family planning services under Title XIX mandatory on the States for cash assistance recipients. In addition, the rate of Federal financial participation for family planning services for both the categorically and medically needy was increased to 90 percent on the date of enactment of the Bill. The Law also provides a penalty of a one percent reduction in the Federal share of AFDC funds if a State fails to (1) inform AFDC adults of the availability of family planning services or (2) fails to provide such services when requested. This provision became effective July 1, 1973.

Medical assistance for family planning includes payments for appropriate medical examinations, diagnosis, medical counseling and treatment, laboratory services, surgical procedures, drugs, supplies and devices. These services may be provided in doctors' offices, clinics, hospitals (on both an inpatient and outpatient basis), family planning center, or any other suitable setting.

Because of the increased responsibilities placed on the State agencies to assure that family planning services are offered and available to all eligible persons who wish to utilize them, the increased Federal matching, and the expected transfer from Title IV-A as States reach their social services ceiling, a sizeable increase is expected in Title XIX expenditures for family planning from FY72 through FY75.

V

OFFICE OF EDUCATION

Summary of Programs Related to Family Life, Sex Education, and Population Growth

The Office of Education, through its varied grant programs made possible under general legislation, has enabled education institutions at all levels to include family life, sex education and population education in their programs and has given limited Federal support to innovative projects. Plans are developed by State education agencies, local school districts, and colleges and universities.

Acting within framework of State law, State and local authorities make all decisions about what is taught, teaching methods, qualifications of teachers and materials used in the classroom.

The Elementary and Secondary Education Act of 1965, (P.L. 89-10) and its amendments provide several titles under which family life and sex education activities are eligible for support. The purposes of Title I are to assist in expanding and improving education programs which contribute particularly to meeting the special educational needs of educationally deprived children; namely, through payments to State educational agencies for:

1. Grants to local educational agencies having concentrations of children from low-income families.
2. Grants to State agencies operating or supporting schools for handicapped children.
3. Grants to State agencies operating or supporting institutions for delinquent or neglected children.
4. Grants to State educational agencies for establishing or improving programs for children of migratory agriculture workers.
5. Administering the program.

In addition, payments are made to the Secretary of the Interior for grants with respect to educationally deprived Indian children in Bureau of Indian Affairs schools and for payments by the Secretary of the Interior to local educational agencies with respect to the out-of-State Indian children in elementary or secondary schools of such agencies under special contracts with the Department of Interior.

Grantees may use the money for programs for dropouts, pre-schoolers, and teen-age unwed mothers, or other approaches to remedying educational deprivation.

ESEA, Title III, Supplementary Educational Centers and Services, enables schools to provide programs presently unavailable to children, to raise the quality of educational services already offered, and to stimulate the development and evaluation of experimental elementary and secondary education programs to serve as models. Fifteen percent of program funds is mandated for projects serving handicapped children. Other funds are mandated for projects in guidance, counseling and testing.

Originally, the Commissioner made grants directly to local education agencies. Beginning in fiscal year 1971, 85 percent of Title III funds were administered by State educational agencies, with fifteen percent to be used at the Commissioner's discretion within the State.

Although not specifically dealing directly with Family Life and Sex Education, the Title III projects in environmental education provide information on population-environmental affairs.

Title VIII, Section 807, the dropout prevention program of the Elementary and Secondary Education Act has no family planning program as such. However, projects in Miami, Florida and St. Louis, Missouri have components of "Continuing Education." These programs are designed for young pregnant girls. Their training is in pre- and post-natal care, personal grooming, child care, and personal counselling. These are areas that are related to family planning programs. Emphasis, of course, is on keeping the girls up in their school work so that they can go back to regular school or develop a skill so that they are employable.

Under this section, appropriations are authorized for the establishment by the Commissioner of Education, under contract grant or otherwise with local educational agencies, of projects in low-income areas and in areas where a high percentage of children do not complete elementary or secondary school education. Demonstration projects involving the use of innovative methods, materials, systems or programs, designed to reduce the number of dropouts, may be supported.

Since pregnancy and/or early marriage constitute the largest cause of dropout by teen-age girls the need for inclusion of family life and sex education in a comprehensive school program is apparent.

Title I of the Higher Education Act of 1965 (P.L. 89-329) provides financial support to encourage colleges and universities to assist in the solution of community problems through specially designed continuing education and community service programs. A State desiring to receive its allotment of Federal funds under this Title must designate or create a State Agency which is required to submit an annually amended State plan to the U.S. Commissioner of Education for approval. The plan must set forth administrative policies and procedures and identify community problems it wishes colleges and universities to attack. The State Agency reviews proposals from institutions of higher education and awards funds to approved projects on a 66 2/3 percent Federal and 33 1/3 percent non-Federal matching basis. During the current fiscal year all States plus Guam, the Virgin Islands, Puerto Rico, American Samoa and the District of Columbia are participating in the program. The request for 1975 is zero (0), compared with a 1974 appropriation of $15,000,000.

Under the Consumer and Homemaking Programs of Vocational Education, P.L. 90-576, Part F, a portion of the instructional time relates to subject matter dealing with family life and child care, growth and development. Some portion of time would be concerned with family planning, but at this time this activity cannot be identified more discretely.

Family planning may be included as a part of the study of family relationships and preparation for marriage and child care, growth and development offered in vocational home economics courses for secondary and post secondary and adult students. Whether a study of family planning is included depends entirely upon the approval of the local community, although there has been increasing acceptance of instruction in this area by the schools. Advisory groups composed of community leaders such as clergymen, school administrators, medical personnel, counselors, and parents make the decision as to the extent the study of family planning is included.

Courses in child care/development which offer preparation for parenthood are an expanding part of consumer and homemaking education programs, both for youth and adults. The study of child development is being given increasing emphasis in comprehensive courses in consumer and homemaking. Enrollments in specialized courses in the area have expanded from 4,038 in Fiscal Year 1966 to 77,158 in Fiscal Year 1972. In both Montgomery County and Prince Georges County, Maryland, child development laboratories are included as a part of the home economics facilities in most of the high schools. Full year courses in child development are offered for students, grades 10 to 12, which include the study of how children grow and develop from the pre-natal stage through childhood. They learn to enjoy children, to relate to them, and how to guide their development. They learn about the responsibilities of parent and other adults for helping children grow, and the resources available in the community for families with children. Also, courses in Family Relations have expanded from 95,367 in Fiscal 1967 to 190,397 in Fiscal Year 1972.

Teenage-parent programs are offered under the leadership of the home economics department in many schools which make it possible for young parents particularly, to continue in school. In Berkley, California, a child care center is provided by the school for the infants and children of school age parents. Young mothers, some fathers, and other students enrolled in child development courses participate in caring for the children under the guidance of a teacher and learn how children grow and develop. In the Granite School District in Utah, a special homemaking center has been set up for pregnant teenagers, both married and unmarried, who do not want to continue in the regular school program. Consumer and homemaking education is a vehicle for teaching Family Life giving specific assistance to girls and boys in preparation for caring for their babies and their future responsibilities. After confinement some teenagers return to regular school and some continue in the special program where provisions in the center are also made for care of the infants by the young mothers themselves.

In one community in Wisconsin, enrollment in courses in family living are required of Family Court Clients. Enrolled in these courses are single parents, parents of youth from poor socioeconomic areas, potential school dropouts, delinquents, unwed parents and foster parents.

A family life education TV series developed by the community college in Oregon last year reached 5,000 people. Each of the 15 lesson series on "Living with Your Child" was followed with a discussion group led by a parent educator. Many of the Future Homemakers of America projects focus on helping children. In some cases, local units develop their own projects;

in others, they assist with established programs such as day care centers, Headstart programs and schools for the handicapped. The members apply what they have learned about children in child development classes and they also gain a better understanding of themselves.

In cooperation with local Public Housing Authorities, school districts provide Family Life Education Programs for low-income families in major cities in Ohio, Georgia, Washington, Texas and other States. Some of these programs are of long standing. Classroom space (one or two apartments), large equipment and some supplies are made available by the Housing Authorities.

In Wisconsin, credit courses in "Marriage for the Now Generation," offered in the postsecondary vocational schools are of interest to students. One postsecondary vocational-technical school in Montana requires that each student enroll in a course on consumer education before he completes his program. In Georgia, 26 postsecondary schools offer courses in consumer and family life skills.

The number of consumer and homemaking education programs in middle and junior high schools is growing. Grade levels included range from the fourth through the eighth grades. In South Carolina, the program is offered for sixth, seventh, and eighth graders, focusing on four areas: Personal Relationships, Personal Health, Personal Environment, and Personal Development. In Pennsylvania, programs are offered to fifth and sixth graders. In some schools, classes are held in the home economics department and in others, the teacher goes to the elementary school classroom.

The Adult Education Act of 1966 as amended (P.L. 91-230, Title III) may be identified as a significant program which serves families through education. Designed for under-educated adults, primarily those 18-44 years of age with less than an 8th grade education, the programs overarching objective is to enable the adults who participate to become employable, productive and responsible citizens as well as self-reliant and competent individuals, parents and family members.

Through grants to the State Departments of Education, matched by State and local funds, opportunities are provided in local communities for adults to improve their learning and communication skills--reading, speaking, writing and their computation skills and also to acquire information needed on the job, in the home and community. Family-related concerns of participants, many of whom are parents and heads of families, are reflected in the curricula. There is an increasing emphasis on homemaking and consumer education, nutrition, family development, family planning, sex education, and parent education.

It is estimated that fifteen percent (15%) of all the effort in Adult Education under the State grant program is related to some aspect of family life and sex education.

In addition to the State grant programs, funds are authorized for Special Experimental and Demonstration projects and for a National Teacher Training Program. Priorities for funding for FY 1973 included Education for educationally disadvantaged parents. Four projects were funded in FY 1973 under this priority with grants totaling $528,949. An additional twelve projects funded in FY 1973 are concerned with family-related content in programs for a variety of parent populations. The estimated total expenditure for family life components in these projects is approximately $600,000. This makes a total of over one million dollars expended for areas of family-related sex education from FY 1973 funds. Since a number of the family-related Special Projects will be refunded in FY 1974, the expenditure for this FY is estimated at approximately $500,000. No new family-related projects will be funded since this is not a FY 74 priority, however, some of the projects funded under other priorities--Adult Career Education, Adult Secondary Education, Strengthening State Adult Education Programs--will include family-related components.

The four Special Projects funded in FY 1973 under the priority Adult Education for Educationally Disadvantaged Parents have the following objectives:

(1) The National Council for Negro Women, Washington, D.C. through Project COPE is developing an ABE model which seeks to improve the life styles of female solo parents. The model will be disseminated to the Nationwide membership of NCNW as well as the ABE field.

(2) Granite School District, Salt Lake City, Utah, and the cooperating Los Angeles City School System are focusing on parent effectiveness in helping parents learn to provide a rich, stimulating home environment for their school children.

(3) Montal Educational Associates is developing a model education program for Spanish-speaking parents of children in Head Start.

(4) Oakland, California Unified School District in coordination with the State and local ABE program is developing a model Adult Education program for native American parents.

Other family-focused projects involve different cultural and ethnic groups--urban Black, Chinese, Puerto Rican, Southern rural, Mexican-American, Native Hawaiian, including home-related ESL where pertinent.

VI
DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
POPULATION RESEARCH AND FAMILY PLANNING ACTIVITIES

Obligations, FY 1970 -- FY 1974

Agency and Program	Fiscal Year				
	1971	1972	1973	1974 (Est)	1975 (Est)
Total, Department of Health, Education and Welfare	$107,367,000	$202,023,000	$245,542,000	$321,168,000	$287,865,000
PUBLIC HEALTH SERVICE					
Health Service Administration					
Bureau of Community Health Services					
Maternal and Child Health					
Formula grants to States	$11,700,000	$11,700,000	$11,700,000	$11,700,000	$35,200,000
Project grants for maternity and infant care	4,500,000	4,500,000	4,500,000	4,500,000	---
Research	500,000	200,000	100,000	100,000	100,000
Family Planning	33,275,000	96,656,000	107,207,000	153,653,000	103,998,000 1/
Subtotal, Community Health Services	49,975,000	113,056,000	123,507,000	169,953,000	139,298,000
Federal Health Programs	309,000	386,000	268,000	360,000	367,000
Indian Health Services	600,000	754,000	896,000	1,080,000	1,221,000
Total, Health Services Administration	50,884,000	114,196,000	124,671,000	171,393,000	140,886,000
Center for Disease Control	15,000	55,000	55,000	55,000	55,000

1/ Excludes $19,000,000 for Title V grants being requested under maternal and child health formula grants.

Obligations, FY 1971 -- FY 1975 (Cont'd)

Agency and Program	Fiscal Year				
	1971	1972	1973	1974 (Est)	1975 (Est)
National Institutes of Health					
National Institute of Child Health and Human Development	$28,375,000	$39,973,000	$38,849,000	$51,347,000	$45,874,000
Alcohol, Drug Abuse, and Mental Health Administration					
National Institute of Mental Health	284,000	100,000	100,000	100,000	100,000
Health Resources Administration					
National Center for Health Statistics	396,000	842,000	461,000	450,000	450,000
Health Manpower, Training	332,000	428,000	---	---	---
Subtotal	728,000	1,270,000	461,000	450,000	450,000
Total, Public Health Service	$80,268,000	$155,594,000	$164,136,000	$223,345,000	$187,365,000
SOCIAL AND REHABILITATION SERVICE					
Social Services	12,300,000	28,200,000	53,400,000	56,100,000	64,500,000
Medical Assistance	6,459,000	8,700,000	18,200,000	30,600,000	36,000,000
Subtotal, Social and Rehabilitation Service	18,759,000	36,900,000	71,600,000	86,700,000	100,500,000

Obligations, FY 1971 -- FY 1975 (Cont'd)

Agency and Program	Fiscal Year 1971	1972	1973	1974 (Est)	1975 (Est)
OFFICE OF EDUCATION					
Elementary and Secondary Education					
Supplementary Education Centers and Services	$800,000	$582,000	$582,000	$272,000	2/
Dropout Prevention Programs	40,000	40,000	40,000	30,000	---
Higher Education					
Grants to States for Community Service and Continuing Education	400,000	338,000	199,000	235,000	---
Prospective Elementary and Secondary Teacher Fellowships	150,000	150,000	---	---	---
EPDA Institute Programs	---	---	---	---	---
Adult Education					
Adult Basic Education Programs	4,819,000	5,578,000	5,613,000	8,023,000	2/
Grants to States for Vocational Education	2,125,000	2,560,000	3,072,000	2,563,000	2/
Environmental Education	6,000	281,000	300,000	---	2/
Total, Office of Education	8,340,000	9,529,000	9,806,000	11,123,000	---
Scientific Activities Overseas 3/ (Special Foreign Currency Programs, P.L. 480)	1,673,000	726,000	909,000	700,000	957,000

2/ Funds have been consolidated under a proposed Consolidated Education Grants legislation.

3/ Not included in the DHEW total.

HEARING AND SPEECH

Obligations Fiscal Year 1971 to Fiscal Year 1975

Agency and Program	1971	1972	1973	1974	1975
SOCIAL AND REHABILITATION SERVICE:					
Rehabilitation Services Administration:					
Basic State grants..	$31,700,000	$31,304,000	$33,495,000	$33,579,000	$34,170,000
Innovation grants...	159,000	---	---	---	---
Service projects....	160,000	310,000	280,000	140,000	---
Rehabilitation training..........	4,863,995	832,540	3,767,067	270,800	1,150,000
Rehabilitation Research and demonstrations.........	1,850,000	1,678,000	1,000,000	500,000	800,000
Rehabilitation Research and training centers..	250,000	354,000	500,000	400,000	250,000
Subtotal, Rehabilitation Services...	38,982,995	34,478,540	39,042,067	34,889,800	36,370,000
Office of Planning, Research and Evaluation:					
Special foreign currency program..	---	513,725	400,000	200,000	200,000
Subtotal, Social and Rehabilitation Service..........	38,982,995	34,992,265	39,442,067	35,089,800	36,570,000
OFFICE OF EDUCATION:					
Elementary and secondary.....	$ 13,400,000	$ 14,000,000	$ 13,800,000	$ 13,800,000	$ 1/
Education for the handcapped........	36,412,000	34,645,000	34,808,674	38,276,000	23,700,000 2/
Occupational, vocational, and adult education	4,463,624	4,729,500	4,883,200	4,800,000	1/
Library resources	40,000	40,000	50,000	40,000	40,000
Research and training......	88,800	68,143	3/	---	---
National Advisory Committee on the Handicapped 4/	100,000	100,000	26,081	40,000	70,000
Subtotal, Office of Education..	54,504,424	53,582,643	53,567,955	56,956,000	23,810,000

HEARING AND SPEECH

Obligations Fiscal Year 1971 to Fiscal Year 1975

Agency and Program	1971	1972	1973	1974	1975
PUBLIC HEALTH SERVICE:					
Health Services Administration:					
Community Health Services......	2,801,464	3,155,000	3,970,500	3,998,500	4,027,500
National Institutes of Health:					
National Institute of Neurological Diseases and Stroke........	9,160,000	11,446,000	10,240,000	14,698,000	12,742,000
National Institute of Child Health and Human Development...	8,394,000	10,810,000	11,869,000	12,950,000	12,250,000
National Institute of Dental Research......	1,685,210	1,461,102	1,774,053	1,733,300	1,277,100
National Institute of Environmental Health Sciences	---	---	212,000	245,000	245,000
Subtotal, National Institutes of Health........	19,239,210	23,717,102	24,095,053	29,626,300	26,514,100
Subtotal, Public Health Service	22,040,674	26,872,102	28,065,553	33,624,800	30,541,600
SPECIAL INSTITUTIONS:					
National Technical Institute for the Deaf......	$ 4,200,000	$ 30,826,000	$ 7,223,000	$ 7,226,000	$ 10,756,000
Gallaudet College 5/....	12,141,000	14,534,000	28,280,000	25,661,000	28,304,000
Subtotal, Office of the Secretary.....	16,341,000	45,360,000	35,503,000	32,887,000	39,060,000
TOTAL, DEPARTMENT OF HEALTH, EDUCATION AND WELFARE.......	$131,869,093	$160,807,010	$156,578,575	$158,557,600	$129,981,600

HEARING AND SPEECH

Obligations Fiscal Year 1971 to Fiscal Year 1975

1/ The programs in these activities which supplied funds for hearing and speech are being consolidated, in fiscal year 1975, into the Consolidated Education Grants legislation.

2/ The State grant program is being consolidated, in fiscal year 1975, into the Consolidated Education Grants legislation.

3/ Program transferred to the National Institute of Education in fiscal year 1973.

4/ From 1971-1973, amounts are for the National Advisory Committee on Education of the Deaf; in 1974 this Committee combined functions with the National Advisory Committee on Handicapped Children to form a new National Advisory Committee on the Handicapped. This activity was previously reported under the Office of the Secretary.

5/ In FY 1975 the appropriation for Gallaudet College will include the Model Secondary School for the Deaf.

PROGRAMS IN HEARING, SPEECH, AND LANGUAGE

PREFACE

The Subcommittee on Human Communication and its Disorders, National Institute on Neurological Diseases and Stroke disclosed in its 1969 report on the prevalence of handicapping communicative disorders that over 20,000,000 Americans are afflicted. It is estimated that 10,000,000 have handicapping speech disorders such as stuttering, laryngectomy and cleft palate, 8,500,000 have hearing impairments and 2,100,000 have a central communicative disorder such as aphasia and mental retardation.

Offsetting this distressing situation is the fact that more and more speech, hearing and language handicapped persons are being aided in becoming self-sustaining and contributive members of society. Research in the fields of medicine, rehabilitation and education has been a vital force in exploring, devising and demonstrating techniques and devices that are helping more people with communicative disorders to overcome their handicaps completely or in part. A growing supply of trained manpower is combining with innovative rehabilitation techniques, new medical and surgical processes, improved prostheses, refinements in language and speech therapy and other communication aids in affecting full or partial restoration of hearing and speech power in significant numbers of persons.

Challenging opportunities in mounting effective programs to meet the needs of persons with communicative disorders have been possible through legislative authorization and appropriations for the handicapped. Some of the more outstanding activities being undertaken by the Social and Rehabilitation Service, the Health Services Administration, and the Office of Education are mentioned here.

The Social and Rehabilitation Service through its program of training and research in speech pathology and audiology and rehabilitation of deaf persons continues its investment in people with communicative disorders who need assistance. Rehabilitation Services Administration training programs have supplied approximately 2,700 speech pathologists and audiologists to rehabilitation settings which provide services to adults with communicative disorders. Annually, RSA trains approximately 50 vocational rehabilitation counselors and allied professionals and paraprofessionals in service to deaf people. A major manpower study has made available guidelines on effective use of paraprofessionals in many rehabilitation activities affecting deaf, hearing, speech and language handicapped persons. The rehabilitation of adult aphasics has become much more widely understood through short-term training courses. A national census for the deaf completed in 1973 will yield critical data for rehabilitation and education program planning. Demonstration vocational-technical programs for deaf people at junior colleges are opening new and better employment opportunities and stimulating the development of similar programs at other schools. Greater involvement of parents in the habilitation and rehabilitation of their deaf children is the promising outcome of short-term training courses. The dissemination of current information on research and training to the growing body of professionals in the field of deafness is being implemented through an annual monograph. Research has provided needed models in community service to deaf people including coordination, diagnosis, evaluation, counseling and supportive services. Professional interpreting is constantly being improved to provide deaf people with this critically needed authorized vocational rehabilitation case service. Development and implementation of a model State-wide plan of vocational rehabilitation services by State vocational rehabilitation coordinators of services to deaf and severely hearing impaired people, who organized in 1972, will enhance this program specialty. An important start has been made in investigating discrimination in employment of deaf people. The development of guidelines for State vocational rehabilitation agencies on services to deaf, hearing, speech and language handicapped public assistance clients will be a consuming short-term project task. The addition of telecommunications as a vocational rehabilitation case service has provided opportunity for counselors serving deaf people to procure teletype equipment to help them break through the telephone communication barrier that in the past has contributed to their immediate job plateaus.

The Office of Education expanded significantly its activities related to improving and enlarging educational opportunities for hearing, speech and language handicapped children during the past year. Over 50,000 deaf and hard of hearing pupils are receiving specialized help from schools and classes appropriately equipped to serve them with an additional 14 percent not being served due to a continuing shortage of teachers and other obstacles. A downward extension of educational services to very young preschoolers is increasing the total number. In fiscal 1973, the State grant program will provide approximately $11,000,000 for hearing and speech. For academic year 1973-74 approximately $4,000,000 was obligated for awards to colleges and universities to help increase the number of professionals trained to work with communicatively handicapped children, for the development of graduate programs in the area of speech pathology and audiology and for research and demonstration projects related to the instruction of children with communication disorders.

Educational research relating to speech and hearing during fiscal 1974 will continue to focus on two major problems: (1) communication problems of the deaf, and (2) effective use of speech therapists. A program of research investigating the comprehension and production of syntactic structures by deaf children is currently being supported. In fiscal year 1973 Media Services and Captioned Films reached more than 3,680 groups of hearing impaired persons of which 1,320 were schools or classes for the deaf. More than 600 captioned educational films are available on loan to schools which also receive extended loan of other education media including filmstrips, transparencies, slides, overhead and filmstrips projectors, projection tables, screens and miscellaneous instructional materials. In fiscal year 1971, 20 State institutions for the deaf and/or State supported institutions for the deaf and blind benefited through the Libraries and Educational Communication program. Estimated enrollment of communicatively handicapped children in Vocational Education programs in fiscal year 1973 include 1000 deaf, 5,000 hard of hearing and 15,000 speech impaired.

The Bureau of Community Health Services continues its activities related to the development, improvement and extension of programs in State health departments and crippled children's agencies for children with hearing and speech disorders. Hearing, speech and language services are an integral part of Community Health Service project grants for comprehensive health services for children and youth who live in poverty areas. About 100 hearing and speech specialists are employed as staff in these projects where they provide screening, diagnostic, preventive, corrective and follow-up services. Special projects related to the hearing and speech field include grants to (1) the Colorado State Department of Health for demonstrations related to hearing conservation; (2) the Iowa Crippled Children's Service to explore developments in providing hearing and speech services to mentally retarded children; (3) the Alaska Department of Health to develop a joint program in audiology with the Indian Health Service. In the area of training, a grant to Vanderbilt University includes an agreement for a cooperative training program with Tennessee State University, a historically black institution, as an attempt to develop new patterns of education to prepare speech pathologists and audiologists to serve children from cultural and linguistic backgrounds which differ from that of the speech and hearing specialist. An objective of the Community Health Service Speech and Hearing Unit has been to aid the profession of speech pathology and audiology in preparing to make its services accessible and available in whatever delivery system eventually evolves as a result of the changes which have been proposed for improved national health services.

The National Institute of Neurological Diseases and Stroke continues to provide insight on the basic physiologic processes involved in both normal and deviant patterns of speech, hearing and language through its comprehensive program of research and training. The NINDS program in communicative disorders includes 132 research projects, including four out-patient clinical research centers, seven contracts, 55 training grants to universities and medical centers, and five multidisciplinary centers. The centers and the individual grants support research on hereditary deafness and hearing loss, and hearing problems caused by noise, old age, drugs, infection, tumors of the hearing nerve, middle ear infections and Meniere's disease. They also support research on speech and language disorders including the severely traumatic speech and language problems which can result from stroke and removal of a traumatized larynx. The Institute is also in the process of analyzing data on thousands of pregnancies whose offspring have been studied for eight years to determine prenatal and early childhood influences on communication disorders.

The National Institute of Child Health and Human Development continues to support research leading to a better understanding of the acquisition and development of the processes associated with normal human communication and the problems of communication associated with mental retardation. The Institute is currently supporting 160 research and training grants concerned with human communication in the context of physiological, social, and intellectual development from a biomedical, psychological, and sociological point of view. In addition, there are 12 Mental Retardation Centers where a wide range of investigations encompassing the biological, behavioral, and social sciences are conducted.

The National Institute of Dental Research continues to support concentrated research on cleft palate, a major handicapping speech disorder in children and adults. The University of Pittsburgh Cleft Palate Center, the Haskins Laboratory in New Haven, Connecticut. Purdue University and the University of Iowa are receiving NIDR support for studies related to problems of speech production.

The National Institute of Environmental Health Sciences supports a program on the effects of noise on hearing utilizing the clinical facilities of Duke University in Durham, North Carolina.

The Office of the Secretary continues to administer programs that promote the development and education of deaf and other communicatively handicapped persons. Within the Office of Child Development, established in 1969, the Bureau of Child Development Services administers Project Head Start which has a 10 percent national enrollment reserved for severely handicapped children including the hearing, speech and language impaired. The National Technical Institute for the Deaf with a current enrollment of 473 students continues its activities related to the provision of post-secondary vocational education, and technical training to deaf persons, training to assist in developing professional manpower to serve the deaf nationally, and to research on education of the deaf in general. Gallaudet College has as its purpose a liberal arts education program for the deaf, a tutorial school for deaf students in need of such training to qualify for college admission, a graduate school program related to deafness and a continuing education program for deaf adults. In 1974, an estimated 968 undergraduates and 137 graduate students will attend the college. The Model Secondary School for the Deaf an open laboratory school on the Gallaudet campus which has a current enrollment of 150 students and a staff of 94, continues the development of its innovative program that is expected to stimulate the development of similarly excellent programs throughout the nation.

SOCIAL AND REHABILITATION SERVICE
REHABILITATION SERVICES ADMINISTRATION
SUMMARY OF PROGRAMS FOR THE DEAF, FOR THE HARD OF HEARING, AND FOR THE SPEECH IMPAIRED

The Rehabilitation Act of 1973 with its emphasis on service to the most severely handicapped which encompasses serious communicative disorders creates new opportunities for vocational rehabilitation to carry still further the work of assisting men and women having complex communicative problems to achieve their potential. Recognition of communicative disorder as a severe handicap requiring service priority and innovation in service delivery provides new challenges for the years ahead. The important advances that have already been made in rehabilitation of individuals with communicative disorders coupled with the known unmet needs underscores the values of the new authority in the 1973 legislation expanding the vocational rehabilitation service base for the severely handicapped.

This report on the vocational rehabilitation of deaf, hard of hearing and speech impaired persons summarizes significant ongoing and developing activities that are anticipated to increase substantially the number rehabilitated annually.

The Problem in General

Americans who are vocationally handicapped by varying degrees and kinds of communication disorders exceed 20,000,000 in number. Some have disorders of the ears, the normal channels for receiving verbal messages. Some have defects in the vocal mechanisms, the main means for sending verbal messages. Some have disorders of the central nervous system which interfere with receiving and sending even though the ears and vocal apparatus are whole. Some have peripheral involvements that curb free verbalization. Some have combinations of causes.

The complexity and variety of the causes frequently obscure the fact that speech and hearing are variables that fluctuate with physical, mental and emotional conditions. Normal ears, normal mentality, normal vocal mechanisms and so on should result in normal hearing and normal speech. One abnormality or more results in abnormal communication. The person permanently affected faces formidable barriers. Fortunately, the condition for many is transitory due to the wonders of medicine and related disciplines. These are not among the above-named 20,000,000 whose disabilities are constant, who continuously search for ways to reduce the handicap of communication limitation.

Vocational rehabilitation workers share with teachers, audiologists, speech pathologists, medical workers, and others the responsibility to create, extend and improve knowledge and resources by which the communicatively handicapped can attain adjustments commensurate with their mental and residual physical capacities.

The Deaf

Our 450,000 deaf people have very complex problems. Many of them are without useful speech dispite years of training. Many have limited language skills. They receive messages principally through their eyes. They send message by combinations of signs, gestures, speech, and writing. Most of them have normal strength, mobility and intelligence. They strive for achievement within the limitations imposed by society. It is primarily a psychosocial problem. It manifests itself in many ways: underinvolvement in the main stream of community life; limited socializing with fellowmen; lack of acceptance among neighbors, employers, and fellow employees; severe underemployment. It seldom yields at all to medical intervention such as drugs, surgery or prosthesis. It does yield in approximate ratio to the availability in quality and depth of training and adjustment services that stem from comprehensive, expert diagnosis that may involve the disciplines of psychology, audiology, medicine, and education and to public relations activities that stress the deaf person's strengths.

Two deep-seated problem areas for vocational rehabilitation exist with respect to deaf people. First, the most basic and achievable need of the deaf person, specifically skill in reading and writing, has until very recently been insufficiently emphasized in childhood training. Formal training has generally so heavily emphasized the development of speech skills in the deaf child that speech has erroneously assumed the position of being the equivalent of rather than a vehicle for language. To put it another way, teachers of the deaf have focused disproportionate time and energy upon an outlet (speech) for language rather than power in language itself. Language and speech have been referred to interchangeably, confusing professional and lay workers alike. Hence, the handicapping aspects of deafness have often been intensified by a needless wall of language deficiency. Developing interest in total communication (use of speech, fingerspelling, signs, gestures, reading and writing in combinations verbal by individual children) by parents and educators as a better means for early language development in deaf people is a promising new movement.

Second, an incorrect image of the deaf person's potential in verbal communication skills stems from this heavy emphasis on speech and frequently unrealistic publicity that generates from it. These together create everywhere an expectancy in oral communication performance which very few deaf people can fulfill. Employers and others are, thus, not conditioned to look beyond the poor speech for the hidden, often rich, human resources.

The Rehabilitation Services Administration is attacking the roots of underemployment: (1) By encouraging and assisting in the establishment of rehabilitation centers to diagnose and train deaf people: (2) by extending its training operations (a) to reduce the communication barrier facing deaf people by developing standards and new procedures for speech conservation, utilization of telecommunications, instruction in manual communication and interpreting, (b) to qualify more professional workers in psychology, social work, vocational rehabilitation, speech therapy and audiology to work with the deaf, (c) to develop better understanding of the potentials of deaf people among vocational rehabilitation workers and others, including employers and community leaders, (d) to improve the understanding among professional and voluntary workers of how they can assist the State vocational rehabilitation agencies in serving the deaf, and (e) to help deaf people and their co-workers develop more productive concepts of community inter-relationships; (3) by encouraging researchers to study and resolve the many economic, social, and psychological problems associated with deafness; (4) by extending assistance in the establishment of post secondary programs for deaf people; (5) by encouraging and assisting universities in opening new professional fields to deaf people through special programs and placement techniques; (6) by aiding parents to become more involved in the rehabilitation of their deaf children; and (7) by bringing into focus the needs and remedial actions that are unique to the civil rights of deaf people.

The Hard of Hearing

The several million hard of hearing pose quite different problems from the deaf, the two groups cannot be treated as one. Whereas the deaf receive verbal communication almost solely through their eyes, the hard of hearing rely principally upon their ears, even though these are defective. The hard of hearing generally have near-normal speech and language. Their disability often had a late onset as opposed to the early affliction of the deaf. Partial hearing impairment is less a psychosocial than a medical problem and often yields significantly and quickly to medical intervention and prosthesis with speedy return to an old job or a new one.

It is known that the number of individuals with partial hearing loss is far greater than those who have lost their hearing completely. How much greater is unknown. More accurate estimates are needed before the full magnitude and vocational significance of this problem can be assessed. Deteriorating job performance, eventual loss of job, and gradual withdrawal from family and society are three of the more obvious results of gradual and progressive hearing loss. Too few of these people request help from their State divisions of vocational rehabilitation.

The problems of the hard of hearing are many; this the State vocational rehabilitation counselor knows. How best to solve them, no one yet knows. Much remains to be accomplished in helping the hard of hearing person retain the skills he had before the onset of his handicap. Better diagnostic methods need to be developed to permit more successful fitting of hearing aids. Abilities which permit a person to speechread (lipread) successfully are, at present, unidentified. And yet, accurate prediction of such ability would have profound effects on the rehabilitation management of hard of hearing and deaf children as well as adults.

Further attention should also be given to ways of helping the person with progressive hearing loss retain his speech intelligibility while he is losing his major sensory pathway for judging the accuracy of his speech production.

Basic to meeting the vocational rehabilitation needs of our hard of hearing are people to provide the highly specialized services that they need and the places to do it. The Rehabilitation Services Administration is aggressively involved in helping the States to find these fundamental resources.

The Speech Impaired

The speech impaired, including the language impaired, necessarily include many of the deaf and the hard of hearing because normal speech production depends to a great extent upon self-monitoring which in turn depends largely upon the speaker's hearing. We hear ourselves and correct as we go along. It is not the same for the hearing disabled. However, there are also millions of speech impaired whose abnormal or absent output stems from organic disorders other than hearing.

The special needs of stroke victims, particularly those with language problems due to aphasia, have received nation-wide attention. Little is known about the actual incidence of the disability, particularly in its more subtle and partial forms. Also, diagnostic techniques to determine the most appropriate treatment program and the outlook for recovery remain crude and inexact. Unavailability of crucial specialized services within the aphasic's home community particularly language therapy, poses insurmountable problems for most aphasics living outside large metropolitan areas. New methods of extending services to those people and/or training other family members to assume the task must receive high priority. Programmed teaching machines represent one partial solution to this problem, but self-teaching programs must be developed and evaluated. The spotlight of attention given to this affliction merely highlights the problems which are as yet unsolved.

Equal attention has recently been given to cancer victims. In great need of rehabilitation are those who have lost their larynx because of cancer, thus, their ability to produce voice. Such a sudden handicap usually results in loss of job and loss of family responsibility. Training procedures now exist to help the laryngectomees learn to use esophageal speech, but too often those methods fail. Many individuals, therefore, go for the rest of their lives without the ability to speak. Reasons for this failure must be found. Better techniques for identifying those people who will be able to learn esophageal speech--and those who will not--are needed. Programmed learning methods also need to be considered as possible retraining procedures. Pre-surgery personality factors deserve investigation as probable reasons for post-surgery response to rehabilitation efforts.

Stuttering is another wide-spread speech handicap which deserves greater attention. Over 1,000,000 people in the United States suffer from this affliction. The problems of the adult stutterer are particularly damaging and cause the individual to lead a restricted and sterile life. This is true primarily because the speech defect is variable; the stutterer rarely knows when he begins to speak whether he will talk normally or will produce a spasm of muscular tension and an explosion of distorted words. Most stutterers, therefore, remain constantly "on guard" and resort to bizarre tricks and body motions (which themselves attract attention) to avoid stuttering. Some stutterers even pose as deaf to avoid having to speak. Consequently, many stutterers of superior ability accept jobs which requires little or no talking and remain at a level of employment far below their aspirations and capacities. Underemployment, self-imposed, may sometimes be the stutterer's handicap.

Usually, these problems are most resistant to change, even though most of the stutterer's speech problem has been learned and can be unlearned. The reasons for the tenacity of stuttering are unknown. What is particularly puzzling is the fact that for a few persons, long-time stuttering can be eliminated with relative ease. Clinical observation has indicated that there are different types of stutterers. We need to find ways of identifying each kind and the critical factors which determine their response to rehabilitation. Also, better ways of helping stutterers achieve and retain more normal speech must be found. To do this, better methods of judging the effectiveness of speech therapy are needed. The goal is doubly worthwhile since, if the stutterer's speech can be improved, most of the associated psychosocial and vocational problems which his stuttering creates will also be eliminated.

The State vocational rehabilitation agencies find that a major problem is the lack of guidelines that enable staff to relate speech impairment to occupational handicap. Moreover, standards of casework performance and progress in therapy are not so closely defined nor apparent in speech rehabilitation as in other areas. The resources that serve the hard of hearing can be effective for the Administration's drive for more hearing and speech centers relates to speech rehabilitation, too. Additionally, special emphasis is being given (1) to the development of authoritative literature on the handicapping aspects of speech disorders and their treatment and (2) to the fostering of voluntary work for the speech impaired throughout the national community on a level equal to that for the hearing impaired. The development of casework standards as guidelines for vocational rehabilitation counselors serving speech impaired clients has high priority.

Numbers Served by State Vocational Rehabilitation Agencies

The aim of the public vocational rehabilitation program is the preparation of the occupationally handicapped disabled person for suitable employment. The State vocational rehabilitation agencies actually determine eligibility and provide services using grant-in-aid funds administered by the Rehabilitation Services Administration.

All of the resources of the public vocational rehabilitation services are directed toward the occupational adjustment of the person whose disability is a vocational handicap. The media for attaining this end with each client are the case services that are patterned to individual needs. The research, training, and facility development activities of the Rehabilitation Services Administration and the State agencies are carried on for the purpose of strengthening case service techniques, developing new ones, improving the capacities of the case worker and the personnel upon whom he draws, and developing resources for better diagnostic, evaluation, training and restoration services. The dual aim of sharp increases in the quality and quantity of services and persons served permeates the whole program.

The extent to which the State agencies rehabilitated the deaf, the hard of hearing, and the speech impaired in the fiscal year 1972 and the numbers estimated to be rehabilitated in fiscal years 1973 through 1975 are shown in the following table:

NUMBER OF REHABILITANTS OF THE STATE VOCATIONAL REHABILITATION AGENCIES WITH SPEECH AND HEARING IMPAIRMENTS, FISCAL YEARS ENDING JUNE 30 1972-1975

	Estimated and actual number of rehabilitants in fiscal year [1]			
	1972	1973	1974	1975
All rehabilitants	326,138	360,726	375,000	394,000
Number of rehabilitants with major disability of speech or hearing	19,050	19,900	20,000	20,100
Deaf	6,412	6,400	6,500	6,500
Hard of Hearing	10,017	10,700	11,000	11,100
Speech	2,621	2,800	2,500	2,500

The effectiveness of casework rests in appreciable measure upon the joint planning of the counselor and the client. Clients who are hard of hearing or who have serious speech problems of other than hearing origin tax even the most skilled caseworker. Even so, counselor and client do have a line of verbal communication which encourages rapport. They can develop a good rehabilitation plan together. The profoundly deaf client, however, especially that large majority who have serious language deficiencies, are not able to communicate by normal means. This is the crux. There must be communication between counselor and client for effective casework.

The State agencies have recognized this basic factor and are moving to rectify it as qualified workers become available or through special training of current counselors. Forty-five States [2] now have or are actively recruiting staff who may be classified as expert vocational rehabilitation workers for the deaf since they are trained as professional counselors and are also able to communicate by sign language with deaf clients. Several of the States are searching for and others have already secured additional qualified counselors because their caseloads of deaf clients have rapidly grown beyond the capacities of the special staff as their deaf citizens have become aware that the vocational rehabilitation agency is now able to work more effectively with them. Twenty-five States now have coordinators, too, to oversee and develop their vocational rehabilitation programs for the deaf and hearing impaired. The Rehabilitation Services Administration urges that each State have at least two highly skilled vocational rehabilitation counselors for the deaf and preferably that there be one in each metropolitan area.

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[1] Data are actual for fiscal year 1972 and total of all rehabilitants for 1973. Estimates appearing in the President's budget are used for other data for 1973-1975 and will be updated at a later date.

[2] Alabama, Arizona, Arkansas, California, Colorado, Connecticut, District of Columbia, Florida, Georgia, Guam, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin.

A continuing problem in the area of the hard of hearing through the years has been developing and maintaining adequate channels of referral of hard of hearing persons needing vocational rehabilitation services. Major efforts have focused on encouraging the professional, the medical, and the voluntary worker to refer persons with hearing impairment to State vocational rehabilitation agencies for evaluation and consideration of possible services. The results have been disappointing as witnessed by the relatively small number of hard of hearing clients rehabilitated each year as compared to the many thousands needing or able to benefit from our services. The persistence of this problem has encouraged us to look to other channels by which more persons may become knowledgeable of their entitlements under the vocational rehabilitation service. Accordingly, we have now established formal working relationships with the National Hearing Aid Society, a principal feature of which encourages referrals by hearing aid dealers of persons coming to their attention who may be eligible for the services of our State agencies. If this move is as effective as we expect, the number of hard of hearing rehabilitants each year should increase rapidly into the tens of thousands.

Service Centers

Most of the many hearing and speech centers that have been established in the past twenty years have come into being in universities as training and research facilities, in large hospitals as service units. and in metropolitan areas. They fill vital rehabilitation needs in diagnosis, in evaluation, in training, in lipreading, speech, and listening, and in selection of hearing aids. We may have as many as 900 centers of widely varying levels of effectiveness and uneven geographic distribution. Many thousands of people with communication problems are just too far away from even the least of these service centers and even further from the more technical assistance that they may need. For example, a hard of hearing person who is 50 miles away from lipreading instruction, auditory training, hearing aid evaluation, is not likely to be able to travel this distance several times per week for instruction and service. The Rehabilitation Services Administration is attacking this problem directly through encouragement of projects that bring the basic hearing and speech services that the majority of these disabled people need into the local community at a cost that it can afford to maintain, leaving for the more comprehensive center the intricate services needed by more difficult hearing or speech cases.

In this respect the State vocational rehabilitation agencies are making important contributions to the availability of hearing and speech evaluation services through grants to extend and improve vocational rehabilitation services for the communicatively impaired. In 1969 alone, ten State divisions of vocational rehabilitation established facilities or special programs to improve services to the communicatively impaired. Authorizations under Sections 2, 3, and 4(a)(2)(A) were used in the creation of 25 projects at a total cost of over one-half million dollars.

The practical needs of deaf people are little related to speech and hearing centers. Almost all of them have had several years of intensive, expert training in speech and use of residual sound perception in their special schools. The deaf need the same vocational rehabilitation services as other clients, specifically diagnosis, evaluation, training, counseling, and placement, but in language that they understand. There are very few persons in rehabilitation centers or vocational schools who can communicate with deaf people to the point where a good learning situation may be said to exist. Consequently, the Rehabilitation Services Administration has had to concentrate on developing centers where there are expert professional workers for the deaf. Usually, these have proven to be the residential schools for the deaf. Diagnostic, evaluation, prevocational, and adjustment centers have been established or are planned at the State schools for the deaf in twenty-seven 1/ States, an increase of one over the previous year.

Encouraging by-products of this activity is taking place in other States and there are growing efforts by established rehabilitation centers to qualify themselves to serve the deaf. Community service centers for deaf people, relieving residential schools for the deaf of counseling responsibility of deaf adults, are located in ten metropolitan areas and being planned in others.

Justification

The provision of specialized comprehensive rehabilitation services for a significant number of deaf people whose maximum vocational potential has not been reached continues to be a challenging and unmet need. These deaf people who have been estimated to number 100,000 are severely limited in their vocational adjustment due largely to inadequate educational preparation. No appropriate resources for them exist.

Rubella (German measles) epidemics in the 1960's have resulted in large numbers of deaf children having multiple disabilities. These rubella children have been swamping our schools for the deaf and will soon begin to present a new and demanding challenge to rehabilitation agencies.

Deaf persons whose maximum vocational potential has not been reached, who have not had the advantage of special training, have several characteristics which create difficulties for them in entering and holding gainful employment commensurate with their potentials. Some of these characteristics also account for their inability to qualify for existing post-secondary training programs for the deaf. Their problems cluster around vocational, rehabilitation, educational and social underachievement, severely limited skills in communication and adjustment to requirements of daily living and, in some, the presence of secondary physical disabilities.

The majority of these severely handicapped persons have normal strength, intelligence and mobility. Recent research in providing vocational training and adjustment services to deaf persons with serious personal, social and occupational adjustment problems demonstrated that given proper assistance all of them can improve substantially in their ability to live independently and function normally in their families and communities. This assistance needs to be provided on an intensive, long-term basis by staff who are able to communicate with them, possess a full understanding of their handicaps, and are skilled in the use of instructional techniques and tools for overcoming these handicaps.

The authorization in the Rehabilitation Act of 1973 for special projects and demonstrations to provide vocational rehabilitation service which hold promise of expanding or otherwise improving rehabilitation services to handicapped individuals (especially those with the most severe handicaps) including deaf individuals presents means for long-needed project development for severely handicapped deaf people. The projects will at long last make it possible to provide them with the special type of services they need to become employable or better employed.

1/ Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Illinois, Indiana, Louisiana, Maine, Mississippi, Missouri, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, Tennessee, Texas, Vermont, and Wisconsin.

Of long concern to the Rehabilitation Services Administration has been the void in vocational training for deaf clients. The accelerating inroads of automation seem to have sharply reduced the number of entry level jobs by which the deaf have gained their footholds in industry. Consequently, more vocational training has been necessary for deaf people who frequently are poorly served or not at all by overcrowded vocational schools. This has intensified the training void for deaf people that exists between the special school system which generally terminates at 9th grade or less and Gallaudet College, a void which has nurtured and partially perpetuated their serious underemployment. Fortunately, the situation is changing for the better as programs are being developed to meet the various service needs of the deaf adult population.

Accomplishments

The establishment of the National Technical Institute for the Deaf authorized by Public Law 89-36 in 1968 was a very important step toward reducing the underemployment of deaf people. It is contributing vital new concepts in the training of deaf people and through its special job development and placement program open employment that has not had many or even any deaf practitioners. The State vocational rehabilitation agencies are directly involved with every student.

Great strides are being made in vocational training for deaf people at existing facilities. Ongoing demonstration programs at Delgado College, at Seattle Community College and at St. Paul Technical-Vocational Institute are successfully integrating deaf students using support services such as interpreting, notetaking, tutoring and counseling. The three programs have a total enrollment of over two hundred deaf men and women and a long waiting list. New and better employment opportunities are opening to those deaf people as they complete their training. In addition, the programs are stimulating interest at other schools in providing vocational training to deaf individuals.

The Communicative Skills Program, a long-term training project funded by RSA now in its sixth year, continues its work to increase the number of rehabilitation personnel, professionals in allied fields and employers and co-workers of deaf people able to communicate with deaf persons in their sign language. Over eighty universities now offer credit courses in manual communication as a by product of the great awareness and interest generated by the Communicative Skills Program.

The Registry of Interpreters for the Deaf, a former SRS project, is expanding and accelerating its certification program to meet the critical need of State vocational rehabilitation agencies for an adequate supply of certified interpreters to work with counselors serving deaf people. Five schools currently offer training in interpreting. Many more training programs are needed.

DEAFNESS Annual, a document reporting on research and training activities and trends in the area of deafness with a directory of programs and services for the deaf, is an indispensable tool to the State vocational rehabilitation agencies and to professionals serving deaf persons. The Professional Rehabilitation Workers with the Adult Deaf, which prepares and publishes the annual report, began this work as a SRS project.

Six States, California, Wisconsin, Minnesota, Indiana, Utah and Ohio, are developing mental health programs for deaf people. The State of New York which absorbed the pioneering RSA supported demonstration mental health project for the deaf at the New York Psychiatric Institute provides the background for the developing programs. It is anticipated that additional States will commence this needed work as mental health workers who are able to communicate with deaf people become available.

Rehabilitation Services Administration Training Grants in Speech and Hearing (Speech Pathology and Audiology and Rehabilitation of the Deaf)

Rehabilitation Training

		1973 Actual	1974 Estimated	1975 Estimated
SPA and Deaf	Total	$3,767,067	$270,800	$1,150,000

Accomplishments

Direct training grants are available to support training needs in the field of speech pathology and audiology. Since support of rehabilitation training was initiated in 1958, the number of training institutions has grown gradually and commitment of these institutions to train professionals in this specialty has been significant.

The focus in the Rehabilitation Act of 1973 on the severely disabled will impose new demands on the current available manpower providing services to a significant number of communicatively handicapped individuals in this country. Manpower will be needed to serve the deaf and the severely hearing impaired, the stroke patient with aphasia, and the laryngectomee population.

The number of speech pathologists and audiologists trained under the rehabilitation training program since FY 1958 is approximately 2,700. The majority of these workers are presently delivering services in accredited service settings which contribute to the national rehabilitation effort.

Requirements in FY 1975

Although primary reliance for future manpower development in rehabilitation will be placed on general student aid programs administered by the Office of Education, it is expected that continued support will be available in rehabilitation of the deaf and speech pathology and audiology in Fiscal Year 1975. FY 1973 funds included forward funding of training programs conducted in the 1973-1974 academic year.

REHABILITATION RESEARCH AND DEMONSTRATIONS

Hearing and Speech

Recent review and analysis of available data indicate that the actual prevalence of speech, hearing, and language disorders in the United States is double previous estimates. Approximately 20,000,000 persons have communicative handicaps, with at least one-third of these suffering either substantial or severe social, education, and economic disadvantage. This relatively large portion of the handicapped population present a continued challenge to rehabilitation. Most communicative handicaps have their origin in childhood from varied causes, such as birth defect or injury, cultural deprivation, untreated disease, etc., but persist into adulthood. However, other causes occur in later life, such as problems of aphasia-related stroke, accidents, or brain injury, and problems of traumatic hearing loss due to excessive exposure to noise. Continued emphasis must be placed on the development of test instruments to assess the communicative behavior problems in order to facilitate rehabilitative and therapeutic goals.

Computer assisted instruction and programmed materials are being developed for clinical rehabilitation use of speech and hearing handicapped persons. The breakdown of communication barriers will allow for increased work potential and thus increased earnings for such individuals. There must be continued development of clinical procedures to assist aphasic patients, laryngectomees, and stutterers in social adjustment as the individual ~~returns~~ to his family and to the work community. Projects concerned with the rehabilitation of the hard-of-hearing, especially in culturally deprived populations and with the older American, will be encouraged. Greater emphasis must be placed on developing the full vocational potential of persons with varying degrees of speech, hearing, and language disorders.

Deaf

Problem areas for members of the deaf community have been found to include (1) basic language disorders underlying the communication handicap; (2) social and cultural deprivation; and (3) lack of awareness of the vocational opportunities which do exist. Our goals include the stimulation of projects concerned with basic rehabilitative procedures in language, with community efforts on behalf of the deaf, and with the expansion of vocational opportunities.

Projects concerned with expanding vocational and technical education opportunities for deaf persons at the post-secondary education level are in final stages. There are projects in operation concerned with the development of mechanical aids to assist the teaching of language to the deaf. Several projects have begun which deal with the integration of deaf persons into the hearing community; projects concerned with providing mental health services; and projects involved in opening new job opportunities for the under-employed deaf. A major national census of the deaf has been completed and the report will be available early in 1974. A major thrust will be projects focusing on social interactivities of the deaf in hearing settings. Continued emphasis will be placed on the assessment of the potential of multi-purpose rehabilitation settings to serve the deaf community. An important area of focus will be on provision of improved services to severely disadvantaged deaf adults through facility demonstration including a free-standing residential facility. Development of telecommunications, including cable, and exploration of improved training techniques for deaf people are being thoroughly explored.

REHABILITATION RESEARCH AND TRAINING CENTERS

Hearing and Speech

The New York University Deafness Rehabilitation Research and Training Center provides a continuing framework for research and training in the problems of communication as related to the disabilities associated with the totally deaf; conducts research and training in the evaluation and diagnosis, treatment, counseling, training, and placement of individuals with a wide range of speech and hearing disabilities in addition to their major rehabilitation specialities.

In Fiscal Year 1973, New York University Deafness Rehabilitation Research and Training Center and 5 other Research and Training Centers provided approximately 35 short-term courses in speech and hearing to approximately 2,300 professionals and subprofessionals in the rehabilitation-related disciplines. Examples of such training include a course in speech patho-physiology for medical residents, interns, and graduate students; a clinical practicum for speech pathologists in a rehabilitation center; and a course in communication disorders for graduate nursing students, rehabilitation counselors, and social workers. Close working relationships have been established with State rehabilitation agencies in response to expressed research and training needs.

In FY 1973, 45 speech and hearing-related research projects were conducted by all 19 Centers in such areas as technological sensory aids for the deaf, evaluation of speech intelligibility of stroke patients, and the assessment of treatment process for aphasic children.

	1971	1972	1973	1974	1975
Rehabilitation Research and Demonstrations	$1,850,000	$1,678,000	$1,000,000	$500,000	$800,000
Rehabilitation Research and Training Centers	250,000	354,000	500,000	400,000	250,000

HEARING AND SPEECH

Obligations Fiscal Year 1971 to Fiscal Year 1975

Agency and Program	1971	1972	1973	1974	1975
OFFICE OF EDUCATION:					
Elementary and secondary education.	$13,400,000	$14,000,000	$13,800,000	$13,800,000	1/
Education for the handicapped......	36,412,000	34,645,000	34,808,674	38,276,000	23,700,000 2/
Occupational, vocational, and adult education........	4,463,624	4,729,500	4,883,200	4,800,000	1/
Library resources..	40,000	40,000	50,000	40,000	40,000
Research and training..............	88,800	68,143	3/	---	---
National Advisory Committee on the Handicapped 4/....	100,000	100,000	26,081	40,000	70,000
Subtotal, Office of Education..........	$54,504,424	$53,582,643	$53,567,955	$56,956,000	$23,810,000

1/ The programs in these activities which supplied funds for hearing and speach are being consolidated, in fiscal year 1975, into the Consolidated Education Grants legislation.

2/ The State grant program is being consolidated, in fiscal year 1975, into the Consolidated Education Grants legislation

3/ Program transferred to the National Institute of Education in fiscal year 1973.

4/ From 1971-1973, amounts are for the National Advisory Committee on Education of the Deaf; in 1974 this Committee combined functions with the National Advisory Committee on Handicapped Children to form a new National Advisory Committee on the Handicapped. This activity was previously reported under the Office of the Secretary.

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Office of Education

Report on Speech and Hearing

Education for the Handicapped

Grants for Training of Professional Personnel

According to the most recent estimates of the American Speech and Hearing Association, speech and hearing disorders account for more than 20 million handicapped individuals. Of this number approximately 3.1 million possess learning difficulties severe enough to interfere with communication and the development of normal speech and language. 450,000 of these are considered totally deaf, and thereby incapable of understanding speech through the auditory mechanism. The remaining 5 million represent children and adults with significant speech and language difficulties generally unrelated or only in part related to hearing disorders. Among the types of speech and language problems found are those related to stuttering, aphasia, articulation and voice disorders, and developmental language disorders. These problems may be related to other handicaps such as cerebral palsy, mental retardation, learning disabilities, laryngectomy, and emotional disturbance.

For academic year 1973-74 approximately $4,000,000 was obligated for awards for speech and hearing. The Division of Personnel Preparation has moved completely to Program Assistance Grants. While our expectations are that the number of trainees directly supported will rise slightly, we do not delineate all trainees according to distinct areas of handicaps.

In addition, the State Educational agencies expended approximately $500,000, mainly through special study institutes and summer session traineeships in order to upgrade and update the skills and knowledge of inservice speech and hearing personnel.

Although the school-age population of deaf children has remained relatively constant in the past few years, the downward extension of educational services to very young preschoolers has increased the total number. It is estimated that there are over 50,000 deaf pupils in the United States. Due to a shortage of teachers and other obstacles, an additional 14 percent are not receiving the specialized help necessary from schools and classes appropriately equipped to serve these children. A recent survey has identified an annual need for 1,000 new teachers of the deaf plus 1,000 more to overcome existing shortage and annual attrition.

Public Law 87-276, approved September 22, 1961, authorized a grant program of $1.5 million for each of 2 years to accredited public and non-profit institutions of higher learning for the training of teachers of the deaf. This program was extended for an additional year in fiscal year 1964. In the three-year tenure of the act, 1,376 scholarships were awarded to train teachers of the deaf.

The program was expanded in academic year 1965-66 to include, in addition to the training of teachers, the preparation of college instructors, supervisors, administrators, and research personnel as authorized by section 301 of Public Law 88-164. A total of $2,068,350 was utilized in support of the program in the area of education of the deaf.

The program, incorporated by Public Law 85-926, as amended, was extended by Public Law 89-105 in 1965. Further support of the program activities in academic year 1966-67 and 1967-68 was $2,552,180 and $2,832,839, respectively.

For academic year 1973-74, approximately $2,200,000 was awarded for preparation of persons in education of the deaf in addition to other training funds.

The same levels for training will continue for FY 1974 and FY 1975.

Research

The research and demonstration program for handicapped children administered under Public Law 91-230 has become the principal source of funds within the Office of Education relating to speech and hearing problems. During recent years, research has been supported which focused upon a wide variety of problems in this critical area. The largest and most complicated project currently in progress is a national survey of speech and hearing problems in school children. This study was tested with more than 25,000 school children in order to establish the prevalence of a variety of speech and hearing problems. A longitudinal survey is being conducted to ascertain demographic and educational data on 35,000 schoolage deaf children.

Table I - Research and Demonstration Projects in the area of Speech and Hearing supported by the Bureau of Education for the Handicapped: 1964-75

	No. of Grants S&H & HI	Funds for S&H &HI	R&D Funds	Percent
1964............	9	$ 184,691	$ 999,739	18
1965............	9	239,980	2,000,000	11
1966............	21	598,041	5,994,231	9
1967............	24	841,560	8,049,041	10
1968............	14	495,845	10,794,113	4
1969............	16	904,943	12,800,000	7
1970............	5	788,723	13,048,284	6
1971............	4	1,782,503	15,832,059	11
1972............	7	1,429,269	15,043,262	10
1973............	18	1,676,674	9,834,109	17
1974............	15	1,200,000	9,916,000	12
1975............	15	1,200,000	9,916,000	12

A number of investigators are studying testing procedures, both for identification purposes and for suggestions regarding treatment. An investigator at Gallaudet College is experimenting with a variety of electronic aids which can be useful for helping the deaf to speak. As a result of this work many new devices should soon become available to help teachers with the speech problems of deaf youngsters.

Educational research relating to speech and hearing during the past several years continued to focus on two major problems: (1) communication problems of the deaf, and (2) effective use of speech therapists. The communication problems of the deaf still stand out as the greatest single deterrent to a reasonable academic education for these youngsters. A program of research investigating the comprehension and production of syntactic structures by deaf children is currently being supported. Further, a major effort is being supported to develop cost-effective CAI language arts and mathematics programs for deaf children. Additional research and development activities will be sought in this area. It is expected that significant steps will be taken in the solution of how speech therapists can best allocate their resources and time. It has long been known that speech therapists spend a great deal of their time and efforts working with children whose problems would disappear without help anyway sometime in the future. It should soon be possible for therapists to determine just which children would self-correct and which would need special help.

Media Services and Captioned Films

In fiscal year 1973 Media Services and Captioned Films reached more than 3,680 groups of hearing impaired persons. Of these, 1,320 were schools or classes for the deaf. The total audience for theatrical films numbered over one and a half million with a monthly average of 3,200 showings. Users received the films on free loan and were only required to pay return postage. The three regional film libraries were consolidated for more effective services.

The program maintains sixty film depositories which circulate captioned educational films to meet educational needs. More than 600 titles are available. In addition, schools receive extended loan of other educational media, including filmstrips, transparencies, slides, overhead and filmstrip projectors, projection tables, screens and miscellaneous instructional materials.

An extensive training program designed to instruct teachers in the use of new media is closely coordinated with the loan service. Four Regional Media Centers for the Deaf conduct intensive summer institutes on educational technology. One of these centers concentrates on programmed instruction and one is serving as an advanced institute for persons who will supervise media programs in schools for the deaf. Demonstration teams from the Regional Media Centers provide in-service training by conducting two and three-day workshops in schools during the regular academic year. A national symposium on educational technology for administrators of schools for the deaf is an annual event conducted by the center at the University of Nebraska. Other centers are located at the Universities of Massachusetts, and Tennessee and New Mexico State University.

Material development is designed to find practical solutions to problems of the deaf and other handicapped. Examples of these problems include difficulties in acquiring normal use of the English language and abnormalities in visual perception. Programmed instruction, individualization of teaching, and multimedia presentations are among the techniques being explored to meet these problems.

The activities of the program have been broadened to more clearly reflect the expansion of activities. Because of the expanded role authorized by P.L. 91-230 over six million children are potential users of special media services. Limitations on funding however, suggest that the program for the deaf will continue to operate as described, with new funds being used to support demonstrations of the applicability of new media to other areas of the handicapped.

The most recent amendment to the program was the authorization providing for the establishment of a National Center on Educational Media and Materials for the Handicapped. The Center is located at Ohio State University and was procured by competitive contract award process. It provides a setting wherein the fields of special education and educational materials and technology meet to facilitate the development of, training in, information about, and delivery of instructional media and materials for handicapped children. The Center is the nationwide agent and advocate for those regional materials centers and other agencies who develop materials to meet the instructional needs of handicapped children in the process of getting materials to the intended beneficiary.

EHA, Part B, State Plan Program

The 1966 amendment to the Elementary and Secondary Education Act provided under former Title VI-A, now Part B, EHA, P.L. 91,230, a program of support to local education agencies through a State plan program. During fiscal year 1973 $50.0 million was appropriated. It is estimated that approximately $11 million of this amount was expended on behalf of speech and hearing handicapped children. In fiscal year 1974, the sum of $47.5 million was appropriated for this program and approximately $14 million will be expended on behalf of speech and hearing handicapped children. In FY 1975 this State grant program will be part of the proposed Consolidated Education Grant program.

Early Education Assistance

Part C of EHA, P.L. 91-230, enables the Commissioner of Education to make grants or contracts to public and private, non-profit agencies for the development and implementation of model and demonstration programs. These grants are distributed on a broad geographical basis throughout the Nation. Projects also are established in both rural and urban areas. In some large metropolitan communities more than one project may be deemed appropriate.

Support will be given to many lines of attack on the problems of handicapped children that possess professional credibility and recognized expertise. It is intended that there be great diversity among projects so that models will be developed which are applicable to many different handicapping areas and particular environmental areas.

The Act directs that each program be coordinated with the local school system in the community being served. Dissemination of information, in-service training and other aspects of the model programs will be designed to encourage the development of successful early education programs throughout the State and neighboring areas. The Act provides for a Federal share of up to 90 percent of the cost of a project. During 1972-73, the entire early education program, which serves all types of young handicapped children, included 71 local activities and was funded at 7 million dollars. In fiscal year 1973, total obligations for the program were $13,325,000; in fiscal 1974, $16,219,000, and in fiscal year 1975, $14,000,000. Of the total program the portion estimated to be devoted to hearing, speech, and language development is about 20%; in fiscal year 1973, $2,665,000; in fiscal year 1974, $3,244,000; in fiscal year 1975, $2,800,000.

Library Resources

Through fiscal year 1971, funds under Title IV-A of the Library Services and Construction Act were for the purpose of establishing and improving State institutional library services. Residential schools for the handicapped, including hard of hearing, deaf, and speech impaired, may be included in a State plan if these schools are operated or substantially supported by the State. Funds may be used for providing books and other library materials as well as other library services to students in such residential schools under an approved State plan. In fiscal year 1971, 20 State institutions for the deaf and/or State supported institutions for the deaf and blind benefitted through the efforts of this program.

Typical activities included:

Florida:

Since 1968, the Florida school for the deaf has received an annual grant under LSCA, Title IV-A for the purpose of bringing the library up to minimum standards.

Each year books, filmstrips, periodicals, and other materials are purchased. The project aims at improved programming for the use of these materials. In line with this, in 1971, a workshop was held in the library for the librarian media specialist, teachers and a teacher's aide for the purpose of correlating library materials with the curriculum.

Indiana:

The library at the school for the Deaf at Indianapolis has participated in the LSCA IV-A program since 1968. Benefits have included grants for materials and equipment, cataloguing processing and interlibrary loan service from the State library. In addition workshops and onsite training opportunities for the staff were provided.

In December 1971, a landmark in the development of library services was reached with the opening of a modern, attractive up-to-date library in the former gymnasium. The new facilities provides space in the 13,000 volume book collection, periodicals, films, filmstrips, slides, maps, charts, and pictures. In addition study areas and display areas and work space are provided.

Beginning in fiscal year 1972, the Library Services and Construction Act, as amended, provided library services to State institutionalized persons and physically handicapped persons under Title I. Projects involving these activities are being maintained at the 1971 level during fiscal years 1972 through 1975, except for a slight increase in 1973.

Vocational Education

At least ten percent of the basic grant funds under the Vocational Education Amendments of 1968 are mandated to be spent on the handicapped. This category includes those who are hard of hearing, deaf, or speech impaired. From the descriptive reports of the States which are submitted annually, there are a number of programs in which these particular handicapped students are being served.

Illustrations of the kinds of programs carried on in some States are: pre-employment vocational experience programs; vocational printing; office occupation programs for the deaf; pre- and post-testing of occupational aptitudes; utilization of teacher and instructional aides to provide individualized instructions; work adjustment.

Vocational Education reporting system does not collect data for each category of the handicapped.

Estimated enrollments for fiscal year 1973 include 1,000 deaf persons, 5,000 hard of hearing and 15,000 speech impaired. It is estimated the same level of support will be maintained in fiscal year 1974.

Funds provided have been: fiscal year 1971, $3,387,200; fiscal year 1972, $3,790,000; fiscal year 1973, $3,790,000; and fiscal year 1974 estimate, $3,800,000.

Approximately 10% of the funds provided can be identified as having been expended to provide specific programs and services for the deaf, hard of hearing, and/or speech impaired.

Adult Education

Adults with speech or hearing impairments who have not attained the equivalent of a high school education are eligible to attend adult education programs. It is estimated that approximately 2% of the total effort in State grant funds are used for educational programs designed specifically for under-educated adults with such impairments. In fiscal year 1974 it is estimated the same level of support will continue.

In 1975, the State grant programs under Vocational Education and Adult Education are being consolidated under the new consolidated education grant legislative program.

Elementary and Secondary Education

Benefits under Title I of the Elementary and Secondary Education Act were extended to handicapped children in State-operated and State-supported programs under the provisions of the P.L. 89-313 amendment passed by Congress in November of 1965. In fiscal year 1971 more than $7.7 million were awarded State agencies to expand and improve services to more than 20,242 deaf and hard of hearing children in State-operated or State-supported programs. In fiscal year 1972 almost $9.0 million were awarded State agencies on behalf of approximately 21,439 deaf and hard of hearing children under this Federal program. For fiscal year 1973 approximately 22,723 deaf and hard of hearing children received expanded or improved State service with Federal support of $8.8 million. In fiscal year 1973 and fiscal year 1974 the level of funding for this activity is approximately $10 million.

Title III of the Elementary and Secondary Education Act (P.L. 89-10) provides non-matching grants to local education agencies to stimulate and assist in (a) the provision of vitally needed educational services not available in sufficient quantity or quality, and (b) the development and establishment of exemplary educational programs to serve as models for regular school programs. This program gives special consideration to projects that are truly innovative as well as being of high quality and responsive to local needs. At least fifteen percent (15%) of the grant funds are to be devoted to programs for education of handicapped children. In fiscal year 1973 two projects were validated in the area of speech. In fiscal year 1973 and fiscal year 1974, $3.8 million were provided for hearing and speech in each year from Title III.

In fiscal year 1975 the Title I and Title III programs are being included in the new consolidated education grant legislative program.

National Advisory Committee on the Handicapped

The National Advisory Committee on the Handicapped is composed of special educators, persons interested in education and welfare of the handicapped, and regular educators. The Advisory Committee is required by law to carry out the following functions: (1) make recommendations to the Secretary for the development of a system for gathering information on a periodic basis in order to facilitate the assessment of progress and identification of problems in special education; (2) identify emerging needs respecting special education and suggest innovations which give promise of meeting such needs and of otherwise improving the educational prospects of handicapped individuals; and (3) suggest promising areas of inquiry to give direction to the research efforts of the Federal Government in improving the education of the handicapped. In fiscal year 1974 the National Advisory Committee on Education of the Deaf and the National Advisory Committee on Handicapped Children combined functions to form the new National Advisory Committee on the Handicapped.

The obligations for fiscal years 1971-1975 are as follows:

	1971 Actual	1972 Actual	1973 Actual	1974 Estimate	1975 Estimate
Salaries and Expenses	$100,000[1]	$100,000[1]	$26,081[1]	$40,000	$70,000

[1] For the National Advisory Committee on the Education of the Deaf.

Consolidated Education Grant Program

Under the proposed Consolidated Education Grant program, there are currently six broad categories of support: disadvantaged, handicapped, innovation, supporting services, vocational education, and adult education. Within each earmarked category, State and local officials will have greater flexibility in the use of Federal funds to meet their own priorities. No estimate of State obligations for hearing and speech is available under a program such as this, although the expectation is that the States will continue to fund their important programs in the field.

Hearing and Speech

Obligations Fiscal Year 1971 to Fiscal Year 1975

	1971	1972	1973	Estimated 1974	Estimated 1975
Public Health Service:					
Health Services Administration:					
Community health services	$2,801,464	$3,155,000	$3,970,500	$3,998,500	$4,027,500
National Institutes of Health:					
National Institute of Neurological Diseases and Stroke	9,160,000	11,446,000	10,240,000	14,698,000	12,742,000
National Institute of Child Health and Human Development	8,394,000	10,810,000	11,869,000	12,950,000	12,250,000
National Institute of Dental Research	1,685,210	1,461,102	1,774,053	1,733,300	1,277,100
National Institute of Environmental Health Sciences	---	---	212,000	245,000	245,000
Total, National Institutes of Health	19,239,210	23,717,102	24,095,053	29,626,300	26,514,100
Total, Public Health Service	22,040,674	26,872,102	28,065,553	33,624,800	30,541,600

HEALTH SERVICES ADMINISTRATION

Bureau of Community Health Services

Hearing, Speech and Language Disorders Program

(Title V, Social Security Act, Maternal and Child Health)

The Bureau of Community Health Service, Health Services Administration, administers funds appropriated under Title V of the Social Security Act for Maternal and Child Health and Crippled Children's Services. These funds are available as formula grants to State Maternal and Child Health and Crippled Children's agencies, and the included requirement for projects for the comprehensive health care of children and youth, for maternity and infant care, for dental health care, for training of professional personnel and for research related to the health of mothers and children.

The Bureau of Community Health Service assists state and community health agencies in planning, developing and evaluating programs of health services for children including those with communicative disorders of speech, hearing and language. These efforts consist of (1) providing technical assistance by staff which is consonant with the national goals and objectives of the HSA and BCHS (2) initiating, conducting and supporting efforts by grants and contracts to improve speech and hearing services and the related delivery system (3) issuing program guidelines and other material relevant to the needs of professionals and parents (4) reviewing the performance of programs and initiating studies which focus on improving the quality of services, the extension of services, and the training of personnel, as related to the development and disorders of speech, hearing and language.

The data in the table accompanying this report represent the obligations and expenditures for speech and hearing services which have been included in the different categories of project grants. The amounts expended by the States for speech and hearing services under Title V formula grants have not been uniformly reported by all states and thus, the total national cost of the program for speech and hearing is not identified.

The Problem

Of the 83.8 million children who were under 21 years of age in the United States in 1970, there were 9 million who were handicapped according to estimates prepared by the Rand Corporation for the Secretary of the Department of Health, Education and Welfare (R-1220-HEW, May 1973, p. 273). Among these 9 million there are 2.7 million with hearing and speech impairments. This estimate of the prevalence, when compared to the estimate that there are 2.8 million who are mentally retarded, is a clear indication that communication disorders are of such magnitude that a significant effort is required in the prevention, detection and treatment of these problems.

Studies have shown that the child, who, from birth or early years, has a hearing loss, must receive rehabilitation and training early if his handicap in communication is to be effectively managed. The fact is that for many children the treatment programs have often been delayed until the school years. The recent success of educational leaders in achieving legislation in many states to require educational services for handicapped children at preschool ages is a compelling reason for health services to increase their efforts to find and diagnose children whose handicaps may include communication disorders.

The etiologies of hearing impairment can be roughly divided into two categories which are susceptible to preventive actions, early detection and early and comprehensive treatment. One category includes those conditions related to maternal health, the course of the pregnancy, the delivery and aftercare. This category requires the provision of comprehensive health services for the mother and newborn. The other category includes those hearing problems related to middle ear disease and dysfunction. This category requires that the detection of the hearing problem be accomplished as early as possible to avoid further medical complications and the effect of deprivation of auditory stimuli. Accurate diagnoses must be made promptly so that treatment can be planned which is appropriate and most likely to help the child achieve his potentials.

Speech and language problems can be an indication of general developmental problems and therefore are frequently the reason for parents seeking health services. While treatment and training has often been directed solely at the child's speech and language impairments, there has been an increasing capability in the resources for speech pathology and audiology to use the efforts of multiple disciplines thus avoiding some of the fragmentation inherent in looking at the disorder alone. To meet this need for team oriented clinicians there is required a further development of interdisciplinary training programs and the further refinement of standards of quality of care.

As this nation faces the problem of increasing the effectiveness of care while at the same time reducing its cost, one of the objectives must be to improve the continuity of services. The treatment program for communicative disorders requires coordination between the health service specialists and the school clinicians, and between clinical services and the home. For such continuity to be established and improved, there must be a continuing coordination among the leaders in speech pathology and audiology at all levels of the government.

Goals

The BCHS program for speech and hearing services is guided by the following goals:

1. To assist State and community health agencies to develop additional programs and to extend present programs, especially to infancy and early childhood, for the prevention, identification, diagnosis and treatment of communicative disorders of hearing, speech and language.

2. To develop and improve, with technical and financial assistance, the quality of the personnel and facilities available to serve children with hearing, speech and language disorders.

3. To identify problems related to providing or improving specialized services and to develop and support studies pertaining to these problems in serving children with communicative handicaps.

State Agency Programs

The services provided in a hearing and speech program in a State Maternal and Child Health or Crippled Children's Service program include medical and surgical treatment, hospitalization and aftercare, audiology and speech pathology services, nursing, social work and psychology services and other health services as required, including the provision of hearing aids. While services for hearing and speech impairments are provided in each of the States, the nature and scope of these services vary among the States and among communities within the States.

Some of the activities related to a hearing and speech program are basically activities related to overall preventive health services and general health care provided to children. For example, the program for immunization is significant in the prevention of disease leading to sensorineural hearing impairments. Similarly, medical treatment of upper respiratory infections, and acute otitis media is a significant part of preventing conductive hearing impairments. Just as the provision of early and necessary health care is an essential part of a hearing and speech program, so hearing and speech services are an essential part of a health delivery system. The health services required for an effective hearing speech and language program include a wide range of disciplines involved in casefinding, assessment, medical and non-medical treatment and therapy, counselling and habilitation.

In most states, either the Maternal and Child Health agency or the Crippled Children's Service agency, or both, employ professionally qualified speech pathologists or audiologists to be responsible for the development and implementation of a program for hearing and speech services. The State departments of health have reported a levelling off in the increase in the number of children whose hearing is tested each year. For fiscal 1972, the hearing of more than six million children was tested. The number of children who are found by these hearing tests to need medical and other help is, on a national average, approximately 2% to 3% of the total. This national average, however, fails to emphasize the fact that in some geographic areas the prevalence of significant hearing impairment is 15% and in Alaska, for instance, it is above 30%. The number of persons who are profoundly deaf from birth is approximately two per thousand in the general population. Speech and hearing programs in State Maternal and Child Health and Crippled Children's Services Agencies provide services both directly and indirectly in a variety of different delivery systems.

Most provide casefinding, preventive and diagnostic services directly by utilizing State personnel at both the professional and supportive personnel level. Treatment services for both hearing and speech impairments in some States are provided by state employed staff, but most often are purchased from existing hearing and speech facilities and from professional personnel in hospitals, rehabilitation centers and other facilities. Speech services are provided as an integral part of the services for children with other handicapping conditions, including mental retardation, cerebral palsy and cleft palate. In fiscal 1972, the total number of children with cerebral palsy served by the Crippled Children's Service was 41,272, with cleft lip and palate, 25,047. The Crippled Children's Service reported providing services to approximately 61,377 children with hearing impairments; of these, 23,707 were serviced for the first time in fiscal 1972.

Bureau of Community Health Service Program

Technical assistance by professionally qualified specialists is provided to State health departments and crippled children's services and to other grantees receiving funds under Title V, Social Security Act, as well as to appropriate voluntary and professional organizations. Financial assistance is provided through grants and contracts for special projects in the area of speech and hearing which are of regional or national significance.

Hearing and speech services are an integral part of Maternal and Child Health Service project grants for comprehensive health services for children and youth who live in poverty areas. The projects provide screening diagnostic, preventive, corrective and followup services for children of families who live in low income areas. About 75 hearing and speech specialists are employed as staff in these projects to provide speech pathology and audiology services.

Special projects specific to the hearing and speech field include grants to (1) the Colorado State Department of Health for demonstrations related to hearing conservation; (2) the Iowa Crippled Children's Service to explore developments in providing hearing and speech services to mentally retarded children; (3) the Alaska Department of Health to develop a joint program in audiology with the Indian Health Service.

Grants for training in speech pathology and audiology have been continued at the Johns Hopkins University, University of Iowa, University of Oklahoma Medical School, the New York University Medical School, and Vanderbilt University Medical School. The grant to Vanderbilt University includes an agreement for a cooperative training program with Tennessee State University, a historically black institution of higher education. This project is developing new patterns of education to prepare speech pathologists and audiologists to serve children whose cultural and linguistic backgrounds differ from that of the speech and hearing specialist.

In addition training for speech pathologists and audiologists is included as one of the more than fifteen health professions which receive support for training in the University Affiliated Training Centers. The purpose of this training is to increase the effectiveness and quality of interdisciplinary and multidisciplinary care to handicapped children.

Grant support has been continued for several research studies related to the service needs of programs supported by Title V funds. A study of computerized audiometry, utilizing the responses evoked by electroencephalography is being supported at the Albert Einstein College of Medicine for the purpose of developing more effective diagnostic tests. A study at the University of Hartford, is concerned with developing automated procedures for evaluating of the language functions in infants and young children with severe auditory impairments. The Langley Porter Neuropsychiatric Institute is conducting a study to describe the development of parent-child communication in families with a child who is deaf. A study of the auditory and visual perceptual deficits related to neonatal jaundice is being carried out at the Pennsylvania Hospital in Philadelphia.

Continuing activities in research under the International program include studies of the methods for the early detection of hearing loss. Such studies are supported with special currency funds in Israel, Poland, and Yugoslavia. A project in Egypt has as its purpose the development of innovative methods of delivering speech and hearing services.

Planning

The accelerating changes in the health delivery system have created a climate for change in the practices and procedures in the speech and hearing area. An objective of the speech and hearing program has been to aid the profession to function effectively in whatever health delivery system is finally evolved. National conferences of leaders in public health, of directors of speech and hearing clinical services, of directors of training in speech pathology and audiology were held over the past three years to implement this objective. As a result, the profession itself has conducted Regional and State meetings and additional meetings will be held in 1974 with the assistance of the BCHS staff. These meetings will include the speech pathologists and audiologists in Children's Hospitals who will consider the issues in the health system within the context of their special role in outreach activities. Recommendations are expected to lead to the extension of services to additional hospitals and to the improvement of the quality in the present hospital speech and hearing centers.

The effort to encourage speech pathologists and audiologists to become knowledgeable in comprehensive planning for health service will be continued. The end result expected is a decrease in the likelihood of fragmentation and overlapping of services and the inefficient use of community resources. A primary target for the effort is the committee structure of the State professional speech and hearing associations.

The long term objective of improving the evaluation of the effectiveness of speech and hearing services has been implemented by a joint effort between BCHS staff and the Minnesota Systems Research Inc. This effort has refined operational definitions and developed a coding system for date collection and analysis related to the projects for health services to children and youth.

In the evaluation of training programs a grant has been made to the University of North Carolina to assess and critically evaluate the evaluative procedures used in the University Affiliated Centers. This activity will be continuing.

In implementing the objective of improving the speech and hearing services provided to minorities, a conference was held in New York City in November 1972 concerned with the needs of the Hispanic population. The BCHS staff participated in planning and conducting the conference and provided part of the support. The recommendations of the conference serve to guide the health service in New York City, and are expected to help shape the training programs. Additional attention is needed to the needs of other groups whose cultural and linguistic patterns do not easily accept the present pattern for providing speech and hearing services.

NATIONAL INSTITUTES OF HEALTH

National Institute of Neurological Diseases and Stroke
National Institute of Child Health and Human Development
National Institute of Dental Research
National Institute of Environmental Health Sciences

HEARING, SPEECH, AND LANGUAGE

NICHD through research and research support promotes a better understanding of normal and abnormal developmental processes in persons of all ages. Research deals with normal acquisition and development of language skills and with problems of communication related to mental retardation. In addition to studying specific aspects of hearing, speech and language, the NICHD studies the role which human communication plays in the individual's physiological, social and intellectual development.

In addition to the Institute's 160 research and training grants, the NICHD supports 12 Mental Retardation Research Centers which conduct a wide range of investigations in the biological, behavioral and social sciences. It is primarily at these centers that the Institute studies language acquisition, development and training of the mentally retarded child. Among the handicaps shared by the mentally retarded, language deficiencies are probably the most common and prevalent.

NIDR is supporting concentrated research on cleft palate (an incomplete closure of the roof of the mouth) and other oral-facial defects. NIDR has awarded 14 research grants, including several to research treatment teams, five training grants and two fellowships for study of this anomaly which occurs once in approximately every 600 births.

The NINDS program in communicative disorders includes 132 research projects, including four out-patient clinical research centers, seven contracts, 55 training grants to universities and medical centers, and five multidisciplinary centers. In addition, the Institute this year created a new Laboratory of Neuro-otology to study the biochemical, anatomic and physiologic processes of the auditory system, basic to developing better methods of preventing and treating auditory disorders.

NINDS also has a Communicative Disorders Section in the Collaborative and Field Research Program which is expanding its directed research to target on new problem areas, particularly those which do not receive funding from other Federal agencies. These areas include improved objective identification of young hearing-impaired children; improved measurement, treatment and prevention of speech and language disorders among adults who have experienced stroke or head trauma; effects of noise on children; noise and speech communication; and improved assessment and treatment of language communicative disorders not apparently attributable to sensory impairments. The Section is currently supporting research on utilizing wearable master hearing aids and a study of the extent to which deaf persons are able to integrate information obtained by lip reading with additional information derived from an electronic analysis of the acoustic speech wave form.

To make research information more readily available to scientists and the public, the Institute has supported an Information Center for Hearing, Speech, and Disorders of Human Communication, located at The Johns Hopkins University Hospital in Baltimore. The Center has sponsored several workshops on communicative processes and problems, has published biblio-profiles and state-of-the-art reports on communicative disorders, and has published a directory of organizations and publications in the hearing and speech field.

HEARING

Hearing and Normal Communication

Persons with hearing handicaps are known to have difficulty acquiring normal verbal skills, yet many of the problems underlying relationships between hearing and speech among normal persons and those with partial hearing and communication remain unanswered. In order to examine some of these unknowns, the NICHD supports research into the child's ability to respond to acoustic stimuli both for pure tone and for language-related complex sound. One investigator at St. Joseph's Hospital in Lancaster, Pennsylvania, for example, recently demonstrated that the heart rate and EEG (brain waves) of the normal and abnormal newborn can be consistently but temporarily changed by simple (pure tone) and complex (speech-like) acoustic signals. When developed into a clinically applicable technique this procedure should provide a reliable measure of an infant's ability to hear.

Even slight hearing impairment may be a serious problem in a child's development because of the essential role hearing plays in normal speech and language development. It is, therefore, critical that hearing abilities be defined early in life. Investigators at the University of Kansas Mental Retardation Research Center use an operant approach to improve assessment of hearing ability in newborn and young children as well as in the difficult-to-test severely retarded individuals. One investigator has been conducting research with newborns to refine procedures to test hearing ability, determine whether sensory feedback is reinforcing to them, and relate their responsiveness to sensory feedback with later intellectual development. Other research, at the Parson State Hospital setting of the Kansas Mental Retardation Center, has developed reliable procedures for obtaining hearing sensitivity information from severely retarded children. This work has been extended in two directions: First, to apply this improved technology to obtain pure tone audiograms on infants as young as seven months of age; second, to modify the procedure for more advanced hearing assessment procedures.

Hearing Disorders

National Institute of Neurological Diseases and Stroke

The ultimate goal of hearing research is prevention, but because the nature of the hearing mechanism is so complex, many auditory problems have eluded amelioration or cure. The answers should come, however, with increasingly precise understanding of anatomic, physiologic and biochemical processes. Much of the NINDS emphasis focuses on these basic functions. Concurrent support is given clinical studies on improved treatment for persons afflicted with hearing problems.

One of the targets for prevention is hereditary deafness. Recent studies indicate that approximately 40 percent of deafness present at birth is hereditary. More than 40 types have been identified, most of them resulting from faults in five or six genes. Two types: (1) recessive microtia (abnormally small ears) and hearing loss; and (2) recessive achalasia (tense gastrointestinal muscles), piebaldism (absence of pigment in skin and hair) and hearing loss were described within the past year by NINDS grantees at The Johns Hopkins University. Better understanding of hereditary deafness can aid counseling of prospective parents.

Another 10 percent of congenital deafness has resulted from prenatal rubella infection. The unique data collected from the NINDS collaborative perinatal study of more than 50,000 women and their offspring which was in progress during the rubella pandemic of 1964 have provided unique information on the correlation of rubella infection and deafness. Studies indicate that about half of the infants whose mothers had rubella during the first three months of pregnancy have deafness. Of these, approximately half also have impaired function of vestibular structures (part of the inner ear concerned with equilibrium which connects to the cochlea, the organ of hearing). Temporal bone studies by NINDS grantees at The Johns Hopkins University have shown varying degrees of vestibular problems, including defects of the cochlear duct and saccule which is sensitive to the pull of gravity. Fortunately, the recently developed rubella vaccine has sharply reduced the incidence of rubella-caused defects in babies.

These data, plus recent advances in virology techniques, can now bolster understanding of the effects of a maternal virus infection on the fetus. Learning how other viruses are implicated in congenital deafness should be of help in improving methods of prevention.

Although increased understanding is leading to better methods of prevention, there is still a great lack of knowledge in this area. Therefore, early identification of infants born deaf or with a hearing loss is vital. Hearing problems can best be managed when they are discovered early. Physicians have relied on using a high risk register to identify infants with a high probability of deafness based on family history.

Screening procedures for all newborns have not proved successful because there has been no reliable test. This year, however, an exciting new apparatus for detecting a continuous lack of response to auditory stimulus has been introduced by an NINDS grantee at Stanford University. The new apparatus, called a "crib-o-gram," consists of a transducer mounted on a crib which can detect infant movement in the crib and record any changes when a test sound is turned on. Criteria for "passing" and "failing" the test have been developed through a control study of 5,000 babies. Infants are considered to hear if their response rates are better than 20 percent, or if there are two distinct arousal responses within two seconds after the test sound. The equipment is capable of testing 6,000 babies throughout the day (although the actual number would be dependent on the number of cribs available). Results are tabulated by computer.

In another contract-supported study, simple test devices suitable for home use by parents are being evaluated as a means of early detection of deafness in very young infants--an approach that would permit large-scale screening.

NINDS-supported researchers at the University of Chicago have developed a research technique for obtaining an objective test of hearing function. It may be useful in small children and hearing-impaired adults. Called electrocochleography, it consists of measuring electrical impulses produced in the cochlea (the organ of hearing located in the inner ear) as they move along various nerve pathways from the cochlea to the brain's cortex. The technique involves passing a fine wire electrode through the eardrum to the promontory of the middle ear, and deriving information on the frequencies from different regions of the cochlea. Results are computerized and emerge as patterns. Conventional audiometry (quantitative and qualitative evaluation of hearing using an instrument known as an audiometer) measures excitation of the entire cochlea, but does not provide information on such specific frequency regions.

Hereditary deafness is not confined to infants. In fact, there are 30 types of hereditary deafness for which onset is delayed. The most common of these is otosclerosis, caused by a dominant gene with variable penetrance. This can be successfully treated and hearing restored in most patients. In otosclerosis, growth of spongy bone in the middle ear immobilizes a small middle ear bone, the stapes, that normally vibrates and conducts sound to the inner ear. Surgery for otosclerosis has been an important advance. It consists of removing and replacing the stapes and is reported to be effective in more than 90 percent of the patients. The procedure has become increasingly safe with development of refined microsurgical techniques.

Research on preventing otosclerosis includes studying the initial defects. Electronmicroscopy and tissue studies show that changes in otosclerotic areas may be due to abnormalities in bone-producing cells (osteocytes) or in certain white blood cells which destroy bone (macrophages). Future biochemical studies may lead to methods of preventing these changes. In some studies sodium fluoride has been demonstrated to arrest the otosclerotic process; it may offer some hope for a treatment with drugs.

Another condition in which surgery can dramatically prevent not only hearing loss but even death is acoustic neuroma. Safe removal of these tumors growing on the sheath covering the acoustic nerve is possible because of striking advances in methods of early diagnosis (sophisticated audiological tests and cerebellopontine angle myelography) and excellent microsurgical techniques. These techniques, coupled with prompt management of post-operative complications, have ushered treatment into a new era, far removed from the days in which high operative mortality rates militated against surgical removal of such tumors.

Surgery is also being used, though sparingly, for some persons with Meniere's disease. This disorder, characterized by hearing loss, tinnitus (ringing in the ears) and vertigo, often will respond to medical measures including diet regulation, control of allergies, and drugs for treating the symptoms. In some persons for whom these measures are not adequate, cryosurgery and ultrasound are occasionally used in the inner ear, destroying the end organ of balance, the vestibule, but preserving cochlear (hearing) function. However, even when surgery is performed, symptoms often recur with a slow progression of hearing loss. The final answer to Meniere's disease is expected to come with increased understanding of inner ear (vestibular) physiology.

More research is also needed on finding drugs beneficial for persons with Meniere's disease. A recent study of the effects of streptomycin on the sensory cells of the vestibular system in animals indicated that the drug could selectively destroy the vestibular apparatus with no damage to the cochlea. This would leave hearing intact. More research is needed, however, to determine the possibility of using this therapy on humans.

Streptomycin can be toxic to persons with normal hearing. It is, in fact, only one of several drugs found to affect hearing. During the past several years, the toxic doses and site of injury were defined, some by NINDS grantees, for dihyrostreptomycin, neomycin, kanamycin and ethacrynic acid. To alert practicing physicians, and acquaint researchers with current knowledge on these and other drugs which may be toxic to hearing, the NINDS-supported Information Center for Hearing, Speech and Disorders of Human Communication this year published a book entitled "Index-Handbook of Ototoxic Agents, 1966-1971."

Still another contributing factor to hearing loss can be otitis media, an inflammation of the middle ear space. Infectious otitis media commonly develops from infection in the nose or nasopharynx. It can cause up to a 35-40 decibel hearing loss if left untreated, but is easily treated with antimicrobial agents and oral or topical decongestants. Serous otitis media results from fluid collecting in the middle ear, often after prolonged blockage of the eustachian tube. Serous otitis media, usually unaccompanied by pain, can also cause hearing losses often undetected for considerable periods of time. Although treatment with oral and topical decongestants, enzymes, and occasionally antibiotics is often effective, loss may reoccur with eustachian tube malfunction. Current research, therefore, is centered on the mechanisms of eustachian tube function and management of tubal disease.

Even when no outside direct causes of hearing loss are evident, with increasing age there is inevitably a variable sensori-neural and discrimination hearing loss. Hearing loss accompanying the aging process remains one of the most prevalent, as yet incurable hearing problems. Scientists have identified pathological changes in the temporal bone, including degeneration of certain inner ear structures. Other studies have indicated that diseases of the blood vessels may be responsible for degeneration seen in presbycusis (loss of hearing of high pitched tones). Studies by NINDS-supported researchers at The Johns Hopkins University, however, indicate that other factors may be involved. They demonstrated a loss in volume but not in number of auditory neurons. A more thorough understanding of auditory anatomy and physiology may provide clues to understanding, and then staving off the occurrence of these unknown variables.

Recent work in auditory physiology is helping to unravel the complex interconnected systems involved in hearing. Tremendous advances in the study of the mechanics of the auditory system have been made with the use of new ultrasensitive techniques. The way information is coded in many nerve fibers is now relatively well understood. Studies indicate that most of these neurons have the same properties so they can be measured in the same way. In the inner ear, however, there are diverse coding properties. Researchers feel that as techniques for electrophysiological recording from animals are employed and improved, more exact understanding of the central auditory pathways can be gained.

Limited understanding of the coding process in the inner ear and the technical difficulties present formidable obstacles to artificially generating the neural information which normally enters the brain via the auditory nerve. Many scientists believe the key to a successful implanted hearing device will be discovering how the normal ear encodes auditory information and how it is utilized by the central nervous system.

Researchers in several universities, medical centers and private industry are working on prosthetic devices for the deaf. This may be one of the most exciting areas of auditory research, but it is also one of the most frustrating. Since development and implantation of prosthetic devices involve working with the brain and nervous system at their most complex level, it is one of the most difficult areas in auditory research.

One type of device commonly referred to as an "implantable hearing aid" is a very small electro-mechanical transducer which causes a mechanical vibration in the inner ear. This device would be most helpful for persons with conductive hearing loss (occurring when sound waves are not transmitted adequately to the inner ear). It might also be able to reduce distortion for some persons with sensori-neural loss. Initial mechanical design of such an aid has been completed. However, other critical problems, including that of foreign-body reaction (scarring), remain to be solved.

Another type of sensory prosthesis under study by NINDS researchers is one which would directly stimulate the auditory nerve, the main nerve of hearing. Patients participating in early prosthesis trials were able to discriminate pitch and amplitude, but were not able to perceive complex tones and speech. Understanding of the coding process would greatly enhance chances for success with this type of prosthesis.

Other researchers are considering direct stimulation of the auditory portions of the brain. Three years experience in the Institute's collaborative program to determine the feasibility of several neural prostheses has provided scientists with valuable information that may have application for development of an auditory prosthesis. Scientists have found that different parts of the brain respond to different tones. It may eventually be possible by stimulating appropriately placed electrode arrays on brain tissue to enable deaf persons to discriminate speech.

While auditory prosthesis research still faces difficult obstacles, research on improving existing aids for the hard of hearing is helping increase the quality and the wearer's efficiency in using residual hearing. Presently, sensory devices are of two kinds: acoustic hearing aids which are wearable sound amplifiers; and sensory coding aids, which convert sound so that it may be sensed through vision or touch. Research on acoustic hearing aids is designed to maximize their usefulness and to gain knowledge of how best to fit and adjust the aids to the wearer's individual needs. The Institute supports work on this at Northwestern University and the Central Institute for the Deaf.

This year the Institutee has had developed, under contract, a master hearing aid which will enable scientists to determine methods for tailoring hearing aids to be of greatest aid to the individual wearers. Research on improving fidelity, increasing ruggedness, and reducing distortion would increase aid efficiency.

Sensory coding aids are in use in prototype forms such as visual speech indicators for speech training. One visual aid to speech reception is mounted on eyeglasses. An NINDS contract with Gallaudet College involves preliminary evaluation of an automatic system for separating out speech sounds and placing them in categories in which the deaf person can tell the sounds apart through lipreading. The system will present its output to the user in either a visual or tactile code.

Another contributing factor to hearing loss is noise. At present, the only method of dealing with hearing loss resulting from excessive noise is prevention. Research supported by NINDS at a number of universities and research centers is providing an understanding of the basic physiological structures and functions that are adversely affected by exposure to noise. Some of these studies are providing a quantitative correlation between noise dosage accumulated over a person's lifetime and impaired hearing.

A recent laboratory study indicates that it is to be expected that even after repeated exposures, approximately 25 percent of people living in neighborhoods near airports and highways will be awakened by each intense airplane or truck noise. It has been established that permanent hearing loss can be produced by loud noise, particularly industrial, or rock-and-roll music. One researcher found that 10 percent of persons listening for two hours to rock-and-roll music at 110 decibels (a unit of sound) would have permanent hearing loss. Damage was found in the organs of Corti of guinea pigs exposed to noise from one minute to 24 hours at 100 to 138 decibels by researchers in Ohio. In addition, there was disintegration and loss of spiral ganglion cells which many scientists feel may be responsible for the permanent hearing loss.

National Institute of Environmental Health Sciences

The noise research conducted and supported by the NIEHS is an integral component of its overall effort to determine what factors in the environment, operating singly or in combination, adversely affect man's health. To precisely evaluate how the ear handles acoustical information, Institute scientists have been working on the development of a middle ear transducer for delivering precisely quantified signals to the inner ear.

Utilizing the clinical facilities of Duke University in Durham, N.C., NIEHS scientists have determined that noise levels in incubators approach hazardous conditions. Studies underway at NIEHS in guinea pigs suggest that the newborn is more sensitive to hearing loss from identical noise levels and duration than is the adult.

As part of the Institute's clinical studies, researchers are working to identify and quantify the levels of excessive noise present in the hospital and to relate these levels to pathophysiological effects on the hospitalized patient.

Other studies include the cardiovascular effects of noise (using myocardiopathic hamsters), the adrenocortical stimulating effects of noise and the effects of noise on the immune system.

National Institute of Dental Research

University of Iowa grantees of the NIDR found that otitis media (inflammation of the middle ear) occurs in most cleft palate patients and that the problem tends to be resolved after age eight in most patients, but not in all. They believe that the cause is the cleft itself, which leads to chronic nasopharyngitis, and that anomalies of the eustachian tube or its musculature may also contribute. Last year the University of Pittsburgh Cleft Palate Center reported that early ear care is vital because it can help prevent handicapping hearing loss in many instances. The scientists said that the mechanism for ear disease in infants with cleft palate is different from that in normal infants. Tests showed that normal babies with ear disease have a two-way mechanical obstruction, while babies with cleft palate have a one-way functional obstruction at the nasal cavity which is connected to the middle ear by a tube known as the eustachian tube. Furthermore, the Pittsburgh team found that the eustachian tube of cleft palate patients was more flaccid and unable to clear fluid normally. Functional failure was found to be due also to muscular dysfunction in the soft palate.

SPEECH

About 10 million people in this country have a speech disorder which significantly interferes with communication; half of these are children, and another sizeable proportion appears in the older age groups.

Normal Speech Development

National Institute of Child Health and Human Development

There is strong evidence that a child's speech is acquired through genetically-determined abilities. In fact, the normal infant is apparently born with a built-in capacity for speech. Most human infants acquire the speech patterns of their immediate environment more effectively than could be expected if "learning" were the only explanation.

In the late 1950's two basic concepts advanced by a Massachusetts Institute of Technology psycholinguist, now supported by the NICHD, revolutionized studies on speech and language. He found that children acquire the rules of language grammar; and that they also acquire rules for transforming the underlying meaning (deep structures) of the language to the spoken word (surface structure). Extending this concept, NICHD-supported investigators at Harvard are now designing and testing methods of assessing linguistic knowledge and communication skills in later childhood.

Another NICHD-supported researcher at Brown University revealed startling evidence that a five-day-old infant can discriminate between speech sounds (phonemes) such as "b" and "p." This research was made possible by two technological advances which were also supported in part by the NICHD. The first is a technique for determining an infant's response to environmental change by recording variations in his non-nutrient suckling motions. These motions, recorded on paper, have been used in a wide variety of infant behavior studies. The second is the recording of precisely controlled synthetic speech sounds through a sophisticated computerized system. This system has also been used to study which parts of the brain are used in speech perception.

As a result of this type of study, scientists are now able to conclude that from an evolutionary view speech perception, and other aspects of human language are genetically based and specific to the human species, but that there is much individual variation. Today, the important questions are not whether speech and language acquisition are species-specific and genetically based, but how many abilities are involved and how variation is determined.

National Institute of Dental Research

Scientists in several laboratories are blocking nerves with local anesthetics to study the relationship between the brain's control of speech and the effects of feedback from motor nerves that control muscles and sensory nerves registering sensations such as heat, pressure and pain.

Local anesthetics used by dentists can affect speech. Some investigators have thought that these drugs act on the sensory nerves. Now, NIDR grantees at the Haskins Laboratories in New Haven, Connecticut, have shown that local anesthetics block nerves which in turn affect the activity of muscles. Moreover, changes in activity are sometimes found in other muscles not directly influenced by the anesthetic. In these instances, it is thought that the drug may have seeped from the tissue where it was injected into the blood stream, been carried to the brain, and there influenced its control of speech.

Scientists at Purdue University, also note that when sensation in the mouth is reduced by anesthesia, the tongue moves more slowly, shifts farther back, and presses harder during speech--all motor effects. Studies at the University of Washington showed that when a portion of the mandibular nerve in the lower jaw was anesthetized, the jaw did not open as wide as usual. The scientists found that the faster the anesthetized person tried to speak, the less freely his jaws moved and the harder it was for him to speak.

Timing patterns affected by muscle control are being studied at the University of Iowa, under NIDR support. In normal speech, the tongue, lips, and walls of the throat move together in regular patterns of distance and speed to produce a particular sound or group of sounds. In general, the farther one part of the mouth--say the tongue--must move from its previous position to make the next sound, the faster it must travel to form the right pattern at the right time. Adults with large mouths must therefore move their tongues faster than those with small mouths to say the same word. The scientists think that some poor speech in patients with palatal clefts may be due to abnormal timing patterns when one part of the mouth is out of phase with the rest.

Related studies supported by the NIDR and NICHD at the Haskins Laboratories in New Haven, Connecticut, show that the speed of normal speech seems to depend upon muscular interactions and limitations rather than an exact reproduction of sound patterns. For example, in rapid speech, lip muscles work harder to complete sounds in the shortened time, but the tongue does not always complete its normal movement patterns and seems to use less force.

Speech Disorders

National Institute of Neurological Diseases and Stroke

Normally, speech activity originates and is organized in the brain's cerebral cortex. Information flows out through particular nerve tracts to the muscles involved in producing speech. There is then a sensory flow back to the central nervous system, probably indicating the position of all the structures related to speech, allowing other brain centers to project the necessary nerve impulses for a smooth flow of motor activity. An interruption in this process often accompanies neurological disorders such as cerebral palsy, stroke, multiple sclerosis, Parkinson's disease, dystonia and many others.

Speech disorders resulting from disturbances in muscular control of the speech mechanism caused by damage to the central and peripheral nervous system are known as dysarthrias. They are believed to be the result of disruption at the lowest level of output. This implies that disturbances within the nervous system can affect any or all aspects of speech production--respiration, phonation, articulation, and resonance. During the past few years, several studies have been made on the perceptual, physiologic, acoustic and rehabilitative aspects of dysarthria.

Recent studies of patients with multiple sclerosis indicated that less than half had significant speech deviation. But a variety of deviant speech dimensions was noted in those who were dysarthric. The severity was related to the extent and severity of motor-nerve involvement. Although studies such as these suggest that dysarthria is an impairment of motor control, other research indicates a high probability of sensory deficit as well, since sensory and motor pathways are in close proximity. For instance, results of a recent study showed significant sensory and perceptual deficits on tests of oral form identification and two-point discrimination of the tongue. Using lateral cineradiography (X-ray motion pictures) researchers were able to describe the nature of the disturbed tongue movements during swallowing and speech in patients with Parkinson's disease. Their results are defining the pattern and sequence of deterioration in vocal tract control in Parkinson's disease and can be applied to other progressive neurologic diseases. Characteristically, patients with Parkinson's disease have tension and rigidity of the muscles directly affecting speech. NINDS-supported scientists utilized bioelectric feedback to reduce lip tension in a patient with Parkinson's disease, removing undesirable lip retraction.

Speech disorders also arise, of course, as a consequence of laryngectomy operations for cancer of the larynx which strikes approximately 6,000 persons each year. Dramatic advances have been made in maintaining or restoring speech function following surgery for removal of the larynx which contains the vocal cords. Improved methods of detection are enabling doctors to make an early diagnosis, before the damage is too widespread. In these cases, conservation surgery is being used--that is, removing only the cancerous parts of the larynx, which provides the best prognosis for a functioning larynx. Following recent approval by the Food and Drug Administration of using teflon (suspended in glycerin) for injections to strengthen remaining tissue, restoration of normal speech and the ability to swallow have been made possible in a large percentage of patients.

An exciting advance in larynx surgery this year was made by scientists in Massachusetts. They used a carbon dioxide laser integrated with an operating microscope to selectively evaporate predetermined amounts of abnormal vocal cord tissue through a laryngoscope. Removal was reported to be precise and rapid. Follow-up examinations indicate normal healing similar to that in clean surgical wounds.

A head and neck registry is being kept at Washington University in St. Louis to maintain statistics on the long-term survival rates and quality of life of patients who have had the larynx removed. For those whose cancer is too widespread for conservation surgery, speech prostheses are being developed by several investigators, while others are studying in animals the possibility of reconstructing a normal larynx. Experimental prosthetic aids include a pneumatic device called the La Barge prosthesis developed by scientists in New York. It involves utilizing esophageal speech which is produced by swallowing air into the esophagus (food pipe) and expelling it with a burp to the mouth where the sound is modulated by the lips and tongue to produce sound. The La Barge prosthesis connects a fistula (hole) in the neck to the esophagus, so that the air used for breathing can also be used for esophageal speech by vibrating remaining tissue. This procedure, which has had limited use by human volunteers, is still in the investigative stage.

A second device, called the Tokoyo larynx, developed at Purdue University, helps to create sound by acting like a wind instrument, making a buzzing sound as air passes through it. The sound is carried through a tube to the mouth, where sounds are modified by the person's articulation.

A third device, called the Western Electric Hand Held Larynx, consists of a vibrator held next to the neck. It generates a pulse which is transmitted through neck tissue, and serves as a sound source. These devices are helping patients produce intelligible speech. However, it is hoped that research on the process of speech production, including frequency, duration and intensity of speech sounds, will lead to better speech aids.

Computers are now being used by several NINDS investigators to provide analysis of the speech process. Other NINDS-supported researchers, at Washington University, St. Louis, and the University of Cincinnati, are working to reconstruct the larynx from natural tissue. Animal studies at Cincinnati, for instance, have shown that a functioning larynx in dogs can be made from their own throat tissues. Studies are now being made to see if this procedure can be successful in baboons, whose upright stance is similar to man's. Construction of the new larynx has been completed, and scientists are now attempting to open it and construct vocal cords.

National Institute of Child Health and Human Development

The term articulation, as applied to human speech, refers to the movements of such structures as the lips, jaw, and tongue and also to the acoustic impression of the utterance. Articulatory problems account for the largest number of speech disorders requiring therapy. NICHD grantees are studying the acquisition and development of normal articulatory behavior to provide a basis for diagnosing and treating articulatory problems.

Nearly 70 percent of the mentally retarded have some articulation problems. Since most retarded children also manifest other language problems, the intelligibility of their communication depends even more on articulation. NICHD-supported investigators at Parsons State Hospital and Training Center and the University of Kansas have developed methods for improving the articulation of retarded children. One of their advances applies to the carry-over of more intelligible speech from therapy to everyday use. This is done by allowing stimuli which occur in the child's natural environment to reinforce correct responses acquired in the therapy session.

National Institute of Dental Research

Establishing the optimum age at which to perform surgical correction of cleft palate is important for the patient's ability to achieve closure of the back wall of the throat (pharynx) and the soft palate (velum) and, therefore, the ability to speak clearly. In a recent retrospective study supported by NIDR at Duke University, young cleft patients were examined and categorized according to age at the time of initial surgery. In patients treated before 17 months of age, it was found that the velopharyngeal closure was successful in 86 percent of the cases; whereas in cases with surgery performed after the patient was more than 30 months of age the success rate was only 52 percent.

In addition to excess nasality, cleft palate speech often is characterized by distortions of fricative sounds, such as the /f/ and the /v/. Because it takes increased pressure in the mouth and controlled air release through a small opening of the lips and teeth (oral port opening) to make these sounds properly, a speech scientist is analyzing the relationship between this oral port opening, the way the front teeth meet (dental occlusion), and pronunciation errors in cleft palate patients and normal individuals.

Among other results, the NIDR-supported scientist at the University of North Carolina found that the child with a cleft palate has greater spaces between the anterior teeth and seems to have more difficulty with the fricative sounds /s/ and /z/ than with the /f/ and /v/.

Because faulty bite or "malocclusion" can affect an individual's ability to articulate sounds, an NIDR grantee is attempting to classify children by the type of speech and by the type of orthodontic problem. By assessing both problems, as well as the results of speech and orthodontic therapies in each child, a University of Arizona scientist hopes to establish guidelines for selecting therapy tailored to each patient's type of malocclusion.

NIDR-supported scientists at the University of Kentucky have found that swallow patterns in lispers are abnormal--more so in lateral lispers than in frontal lispers--and that the patterns remain abnormal as long as lisping persists. Therapy and maturation create changes toward acceptable speech and toward more normal pressure patterns. Their studies also suggest that the side of the tongue is more closely related to speech sound production than the tongue tip and that an inability to use the muscles of the tongue properly underlies defective speech in certain instances.

LANGUAGE

Language, a formal system of signs and symbols commonly used for transmitting and understanding ideas, is usually accomplished through written or spoken words. Everyone must learn it or be at a disadvantage socially and educationally. Currently it is estimated that more than three and one-half million children between the ages of four and seventeen have some degree of language disability.

Normal Language Development

The NICHD has supported a great number of differing projects dealing with the acquisition of language. Because children learn language as a matter of course, the complexity of the acquisition process and of language itself is frequently overlooked. The Institute, however, has encouraged scientists from many disciplines to define unsolved problems and has stimulated research in how children develop language. Many competent child development specialists needed specialized research materials. The NICHD, therefore, developed a research contract with the Haskins Laboratories of New Haven which has provided over 50 scientists with natural and synthetic speech-like stimuli recorded in a precise manner for experiments. As a result advances have been made in speech and language perception which may lead to improved language and reading instruction, as well as better hearing aids for the hard-of-hearing.

Language Disorders

National Institute of Neurological Diseases and Stroke

Disorders affecting language development can be present from birth, often the result of deafness, vocal paralysis, mental subnormality, early infantile autism and specific brain damage. Other children who do not suffer from any of these problems but still fail to develop normal language often have what is known as developmental dysphasia.

Language problems also involve children and adults as a result of brain trauma or stroke. Their condition is usually diagnosed as aphasia, the inability to either assign meaning to words, repeat them or organize words into thoughts. Approaches to language rehabilitation generally follow one of four procedures. They may be based on: language structure (building up to increased levels of structural complexity); language acquisition of the normal child; perception and cognition (subordinating concern for linguistic structures); and stimulus-response combinations.

Research on developmental dysphasia has centered on two approaches: search for evidence of early damage to the central nervous system or for evidence of high-level auditory perceptive deficits. Recent evidence indicates that the latter is involved in dysphasia. NINDS-supported scientists at the Institute of Childhood Aphasia at Stanford University described auditory perceptual impairments, demonstrating that children with developmental dysphasia have difficulty sequencing sounds which they hear. Other research showed that persons with dysphasia have impaired ability to discriminate sounds which require rapid auditory analysis. The findings indicate that dysphasic children do not have the ability to perceive many important speech sounds and therefore fail to develop speech.

Continued research on speech sounds which are artificially slowed down by computer may yield important insight into the mechanisms involved, and may also be useful in therapy for children with dysphasia.

By contrast with the milder dysphasias, the term aphasia is usually reserved for a severe and devastating language disorder which produces anxiety, confusion and torment in its victims who once had normal speech and may have lost it as a result of stroke, brain tumor, or brain infections. Persons with aphasia usually have had a strong language base before onset of the disorder. They frequently have less severe language impairment, their problems are usually restricted to expressive abilities (rather than initial understanding), and the problem can usually be associated with specific brain damage. Aphasia can manifest itself in an individual's listening, speaking, reading and writing abilities. NINDS-supported studies at the Boston Veteran's Hospital showed that not all aspects of the language processes are equally impaired, and persons with aphasia were able to perceive linguistic stress in the same way normal persons do. During the past few years, a test battery for determining the extent of aphasia and for predicting levels of rehabilitative success was developed by NINDS-supported researchers at the University of Iowa. More research is needed to develop methods for testing and measuring language disorders, to determine the nature of the disturbances, and to devise more effective treatment and rehabilitation.

National Institute of Child Health and Human Development

NICHD interest in language disorders is illustrated by large-scale comprehensive research programs on communicative disorders among the mentally retarded at several Mental Retardation Research Centers. In one of these, individual studies are conducted on the mechanisms of language acquisition, cognitive processes employed by the mentally retarded, the structure and use of language, and intervention strategies for enhancing the capabilities of retarded children to acquire language. In collaboration with this project, at the Kansas Center others are developing non-speech systems for teaching language to hearing-impaired retarded children and to severely retarded children with normal hearing. Another investigator, at the Fernald State School Center in Massachusetts, has utilized sense discrimination and behavior modification strategies as a tool for developing reading and verbal skills in children with Down's syndrome. Another project, at Peabody College in Nashville, is based on the assumption that positive intervention of nearly any sort at the earliest possible age is likely to yield beneficial results. Efforts to train toddlers in language skills have demonstrated considerable success.

SHARING RESEARCH FINDINGS

The dissemination of research findings and their application are considered by NIH to be one of its major functions in promoting relevant and appropriate research.

National Institute of Child Health and Human Development

Each of the Institutes involved in communication research has recently held conferences and published proceedings. The latest of a series of conferences supported by NICHD on "Communicating by Language" was entitled "The Role of Speech in Language." The previous conference resulted in a book entitled *Language by Ear and by Eye*. Highlights of this book are summarized in a recently published pamphlet, "The Relationships Between Speech and Reading." Other publications in this NICHD series include *The Speech Process*, *The Genesis of Language*, and *The Reading Process*.

In co-sponsorship with its Mental Retardation Research Centers, the NICHD has also initiated a series of seminars which will result in state-of-the-art documents on aspects of mental retardation. The first seminar dealth with language and the mentally retarded. A publication, *Language of the Mentally Retarded*, based on the first conference has been published. Another publication, *Language Perspectives--Acquisition Retardation and Intervention* based on a second conference will be available soon.

National Institute of Dental Research

Continuing its efforts to identify areas for research emphasis, the NIDR this year conducted three workshops bearing upon speech and hearing research. Also, proceedings of three previous workshops were published: (1) "Cleft Lip & Cleft Palate: Research Relevant to Clinical Management in Dentistry" (*American Journal of Orthodontics*, April 1973); (2) "Clinical Research in Cleft Lip and Cleft Palate: The State of the Art" (*The Cleft Palate Journal*, April 1973); and (3) "Training of Surgical Researchers: Head and Neck--An NIDR Workshop" (*Journal of Dental Research*, July-August 1973).

National Institute of Neurological Diseases and Stroke

The NINDS-supported Information Center has supported a number of workshops during the past few years. The proceedings of many of these have been published, including *Vascular Disorders and Hearing Defects*, *Sensory Input in Hearing Impaired Children*, and both *Neuroanatomy* and *Physiology of the Auditory System*. The Center has also had issued several publications including: *Index-handbook of Ototoxic Agents, 1966-1971*; Biblio-Profiles (including *Homotransplantation*, *Auditory Physiology*, *Otitis Media*, *Surgical Treatment of Deafness*, *Viral Infection and Hearing*, *Neuroanatomy of Speech*, and *Rehabilitation of Language Disorders in Children*); research bibliographies, and two directories: *Information Sources in Hearing, Speech and Communication Disorders*: *Publications* and *Organizations*.

OFFICE OF THE SECRETARY

OFFICE OF HUMAN DEVELOPMENT

Office of Child Development

Hearing and Speech

The Office of Child Development, established in 1969, has advocacy and leadership responsibility for all children, including handicapped children. In line with this responsibility, OCD develops standards and guidelines for health programs and provides technical assistance to State, public and private agencies in an effort to help handicapped children and youth. Within the Office of Child Development, the Bureau of Child Development Services administers Project Head Start, a comprehensive demonstration program for preschool children from low-income families. One of the key components of every Head Start program is the provision of health services, including health education, health screening and the treatment of identified illnesses and conditions. These services are also provided by Head Start demonstration programs, such as Home Start, Parent and Child Centers, and Child and Family Resource Programs.

The goal of the health component of Head Start and all its demonstration programs is to identify and coordinate existing health services to insure provision of health care to preschool children and their families. Head Start centers provide complete care to preschool children and their families. Head Start centers provide complete medical examinations, including visual acuity and hearing tests, and all programs focus on the early identification of health problems. During FY 1974, a two-year pilot effort will be launched in 200 Head Start programs to develop ways to insure maximum use of Medicaid Early and Periodic Screening, Diagnosis and Treatment Services for eligible children 0-6 years of age.

Head Start has always had a policy of encouraging enrollment of handicapped children, including those with speech and hearing defects, but greater emphasis is now being placed on their needs. Project Head Start is in the process of carrying out a mandate contained in the 1972 Amendments to the Economic Opportunity Act, which requires that at least 10% of Head Start's national enrollment consist of handicapped children. Enrollment of handicapped children has risen from 17,000 in 1972 to 37,000 in 1973. As part of the new focus on the handicapped, Head Start programs are developing Speech, Language and Hearing Programs that make use of speech and hearing clinicians and of outside professional personnel in local clinics, centers and agencies. A special manual on the Speech, Language and Hearing program, recently developed for Head Start personnel, outlines a language and communications skills program for nonhandicapped children as well as those with defects requiring professional treatment.

In addition, 14 experimental projects have been launched to demonstrate new approaches to serving handicapped children in Head Start. Eight of these projects are operated by Head Start programs and six are early childhood projects jointly funded by OCD and the Bureau of Education for the Handicapped (BEH) in the Office of Education. Two of the joint OCD/BEH projects focus on speech and hearing handicapping conditions.

NATIONAL TECHNICAL INSTITUTE FOR THE DEAF

Public Law 89-36 authorized the Secretary of the Department of Health, Education, and Welfare to enter into an agreement with an institute of higher education for the establishment and operation of the National Technical Institute for the Deaf (NTID). The Rochester Institute of Technology (RIT), Rochester, New York, was selected as the sponsoring institution. NTID, when construction is completed in FY 74 will be a residential facility offering post-secondary vocational education and technical training to deaf persons in order to prepare them for successful employment, a training center for preparing professional manpower to serve the Nation's deaf population, and a research and demonstration center to study the educational, social and employment aspects of deafness.

The new NTID facilities now under construction have been imaginatively designed in order to place the deaf students in a pleasant but also productive and effective environment. The facilities include an academic complex, a residence hall and a dining hall commons and are scheduled for completion in April 1974. The total current enrollment is 473 students with a planned increase to 700 in FY 75. Current staff which includes instructional, supportive, clerical, administrative, research and training personnel totals 165.

The NTID program includes courses of study designed to: correct deficiencies in the educational backgrounds of incoming students; provide counseling to help students select appropriate technical courses; offer special supportive services (such as interpreting and notetaking) to students; establish liaison with industry for cooperative educational and inservice programs. Audiological evaluations and speech and hearing therapy are major components of the program. Computer technology and instructional television will be used extensively in the development of curricula. NTID also has research and inservice training components.

The obligations for fiscal years 1971-75 are as follows:

	1971 Actual	1972 Actual	1973 Actual	1974 Estimate	1975 Estimate
Salaries and expenses	$3,980,000	$4,636,000	$5,308,000	$5,826,000	$ 8,775,000
Construction	220,000	26,190,000	1,915,000	1,400,000	1,981,000
Total	4,200,000	30,826,000	7,223,000	7,226,000	10,756,000

GALLAUDET COLLEGE

Gallaudet College: Gallaudet College, established in Washington, D.C. by an Act of Congress in 1857, has as its purpose to provide a liberal arts undergraduate education program for the deaf, a tutorial school for deaf students who need such training to qualify for college admission, a graduate school program in fields related to deafness, and a continuing education program for deaf adults. In 1974, an estimated 963 undergraduates and 137 graduate students will attend the College.

In order to promote student development, the College offers a wide variety of learning experiences and instructional options, mediated instruction, significant interaction with the larger society, and experiences which encourage growth toward self-fulfillment, including participation and practice in decision making. In addition, the College offers technical assistance to outside organizations and agencies and services to deaf individuals and persons concerned with the needs of the deaf. In FY 75 implementation of the first phase of a comprehensive plan for research at the College will be initiated.

Model Secondary School for the Deaf: Public Law 89-694 provides for the establishment of day and residential facilities for the secondary education of young persons who are deaf in order to prepare them for college, other advanced training or employment. The Public Law authorizes the Secretary, after consultation with the National Advisory Committee on Education of the Deaf, to enter into construction of such a school. The agreement was signed in May 1969. The completed school will serve residents of the District of Columbia and nearby states of Virginia, West Virginia, Maryland, Pennsylvania, and Delaware. In 1974, MSSD will have an enrollment of about 150 students.

The permanent facilities for the Model Secondary School for the Deaf (MSSD) are presently being constructed on the campus of Gallaudet College. The first phase of construction, including the academic building, will be completed in FY 76.

In one of the boldest experiments in the history of American education, students and staff have come together in a school with no classes, in classrooms with no walls, to seek new ways in which today's young deaf students may be educated toward more productive and meaningful lives. An open laboratory school which employs computer-assisted education, educational television, and individualized instruction, the MSSD is, hopefully, a promise of things to come for schools for the deaf throughout the country. It is expected that the MSSD will provide an exemplary secondary school program to stimulate the development of similarly excellent programs throughout the Nation.

Kendall Demonstration Elementary School: Under P.L. 91-587, Gallaudet College was authorized by Congress to operate Kendall Elementary School as a national demonstration school for the deaf. In 1974, approximately 175 children will attend the school from the Washington, D.C. area.

As a demonstration school, KDES is attempting to develop an exemplary educational program for children from the onset of deafness through the age of 15. The School also provides for a diagnostic center and a parent education program. Because of its special focus, Kendall School is also becoming a source of important research on the learning problems of young deaf children.

The obligations for fiscal years 1971-75 for Gallaudet College are as follows:

	1971 Actual	1972 Actual	1973 Actual	1974 Estimate	1975 Estimate
Salaries and expenses:					
Gallaudet College	$ 6,875,000	$ 7,955,000	$ 8,779,000	$10,218,000	$11,969,000
Model Secondary School	2,189,000	2,533,000	3,101,000	3,975,000	4,408,000
Kendall Demonstration School	691,000	1,214,000	1,905,000	1,995,000	2,312,000
Construction	2,386,000	2,832,000	14,495,000	9,473,000	9,615,000
Total	12,141,000	14,534,000	28,280,000	25,661,000	28,304,000

ALCOHOLISM

Obligations for Programs in Alcoholism

(In thousands of dollars)

	1971	1972	1973	1974 estimate	1975 estimate
Public Health Service:					
Alcohol, Drug Abuse, and Mental Health Administration					
National Institute on Alcohol Abuse and Alcoholism.......	17,306	86,735	76,314	218,523 1/	99,866
Center for Disease Control.....	135	41	---	---	---
Health Services Administration					
Indian Health Services.......	2/	2/	2/	2/	2/
National Institutes of Health					
National Institute of Arthritis, Metabolism, and Digestive Diseases.........	2/	2/	2/	2/	2/
Subtotal, Public Health Service................	17,441	86,776	76,314	218,523 1/	99,866
Social and Rehabilitation Service:					
Community Services Administration:					
Aid to families with dependent children..................	2/	2/	6,412	7,100	8,200
Aid to the permanent and totally disabled...........	2/	2/	28,348	31,200	35,900
Rehabilitation Services Administration:					
Basic State grants...........	24,647	25,714	29,841	31,500	34,170
Innovation grants............	300	---	---	---	---
Expansion grants.............	700	360	360	286	---
Facility improvement.........	64	50	43	42	40
Rehabilitation training......	15	20	48	---	---
Rehabilitation research and demonstrations............	348	---	300	300	500
Special foreign currency program..................	150	---	100	200	200
Subtotal, Social and Rehabilitation Service.	26,224	26,144	65,452	70,628	79,010
Total................	43,665	112,920	141,766	289,151 1/	178,876

1/ Includes $80,614,000 of 1973 released funds.

2/ Obligations not identifiable.

THE SCOPE OF THE PROBLEM

Alcoholism or problem drinking today afflicts an estimated 9 million Americans. Alcohol-related problems are the cause of more than 85,000 deaths in the United States each year. An estimated 2 1/2 million arrests every year are related to alcohol. Alcoholism shortens life expectancy 10 to 12 years. Approximately 35,000 accidental deaths at home, work, or recreation involve abuse of alcohol. One-third of all deaths reported as suicide and one-half of all homicides are alcohol-related. To these statistics must be added immeasurable human costs and suffering--broken homes, deserted families, and psychological problems--resulting from alcohol abuse and alcoholism. Alcoholism affects the lives of some 36 million persons in the United States.

In the past, alcoholism was considered mainly a moral or judicial problem. In recent years, however, alcoholism has become recognized as an illness, and alcoholism and alcohol abuse as major public health problems in our society. Because of the tremendous overlap among complicated social, psychological, physical, and cultural factors associated with the nature and development of these problems, a long-term program is necessary for a better understanding of alcohol, its abuse, and alcoholism in our culture and society, and to integrate help for these problems into routine provision of health and social services.

Alcohol abuse and alcoholism drain the United States economy of at least $15 billion a year. Of this total, $10 billion is attributable to lost work time in business, industry, Government, and the military. Another $2 billion is spent for health and welfare services provided to alcoholic persons and their families. Property damage, medical expenses, and other costs account for another $3 to $3.5 billion annually.

About 5 percent of the nation's work force are alcoholic individuals, while almost another 5 percent are serious alcohol abusers. Although the most visible victims of alcoholism are inhabitants of skid rows across the nation, they represent only 3 to 5 percent of the alcoholic population. Public intoxication, however, usually involving skid row inhabitants, accounts for 50 percent or over one million of all arrests reported annually, including arrests for traffic violations.

Among American Indians, alcoholism is at an epidemic level. The rate is at least 10 percent, or twice as high as the national average. On some American Indian reservations the rate runs from 25 to 50 percent.

Alcohol abuse and alcoholism are recognized as major health problems in most developed and many developing nations, but despite the virtual universality of the problems, there has been very little multinational collaboration in developing more effective methods to combat them.

PUBLIC HEALTH SERVICE

Alcohol, Drug Abuse, and Mental Health Administration
National Institute on Alcohol Abuse and Alcoholism

Among the many interesting developments in the field of alcoholism during the past 3 years, perhaps the most significant event has been the wide-ranging commitment of the Federal government to the problems of alcohol abuse and alcoholism. This commitment signals a change in basic attitudes of the American population, a shift from prior inattention to and neglect of alcohol problems to active interest and concern.

The National Institute on Alcohol Abuse and Alcoholism, created by an Act of the United States Congress (Public Law 91-616), was formally established in May 1971. The Institute develops and supports programs to (1) improve treatment services for alcoholic persons in States and communities, (2) treat and rehabilitate employees with drinking problems in Government and private industry, (3) modify public attitudes toward alcoholism and alcohol-related problems by developing a program of education and public information, (4) train professional and non-professional personnel, and (5) determine through research the causes and prevention of alcoholism and alcohol abuse. This new Institute is rapidly developing a coordinated national alcoholism program. As a step toward the accomplishment of this goal, the National Institute on Alcohol Abuse and Alcoholism is providing funds for the development of adequate treatment services for alcoholic persons, based, whenever possible, on existing services.

Fiscal year 1972 was the Institute's first full year of operations, a year of dynamic growth and challenge. Throughout the country, along with the expansion of programs initiated in FY 1971, new programs for alcoholic people were developed such as those for public inebriates and the alcoholism poverty program.

During FY 1973, the Institute moved substantially closer to its immediate goal of making effective alcoholism treatment available at the local level throughout the Nation. Further, a sound beginning was made toward the long-range goal of the development of effective methods of preventing problem drinking and alcoholism through fostering the concept and practice of responsible alcohol use by sophisticated educational and informational techniques. Emphasis was placed on the extension and greater visibility for the prevention activity of the Institute to accomplish this objective. The development of alternative fiscal resources for community treatment programs was also stimulated in order to expand services and make projects more financially self-sufficient.

The Federal resources administered by the NIAAA reaches States, communities, and individuals through the activities of four operating Divisions: State and Community Assistance Programs, Special Treatment and Rehabilitation Programs, Prevention, and Research.

DIVISION OF STATE AND COMMUNITY ASSISTANCE PROGRAMS

The Division of State and Community Assistance Programs provides policy guidelines, technical and financial aid, coordination, and evaluation to help State and community organizations and facilities to provide improved alcoholism treatment and rehabilitation services.

State Assistance Programs

The State alcoholism formula grant program which was activated in FY 1972 through an appropriation of $30,000,000, was continued during FY 1973 with the same amount of money obligated. Authorized by the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (Public Law 91-616) the formula grant program provides funds to States to assist them in planning, establishing, maintaining, coordinating, and evaluating projects for the development of more effective prevention, treatment, and rehabilitation programs to deal with alcohol abuse and alcoholism. Funds were allotted to the States according to a formula which is based upon relative population, financial need, and the demonstrated need for more effective programs. According to the Act, no State shall receive less that $200,000 (with the exception of Guam, the Virgin Islands, American Samoa, and the Trust Territory of the Pacific Islands). All 50 States, the District of Columbia, Puerto Rico, the Trust Territory of the Pacific Islands, Guam, Samoa, and the Virgin Islands are now participating in the formula grant program.

Plans for decentralization of the State Alcoholism Formula Grant Program during Fiscal Year 1973 were issued in July, 1972.

Past experience has indicated that State plans, developed during the initial years of a program, inevitably serve as the basis for future planning. For such reasons, major emphasis was placed on assisting States in the development and implementation of strong baseline plans, many of which became operational during FY 1973. Each State plan is based upon that State's existing resources, needs, and unique characteristics. The quality of the plans and the scope of the proposed activities vary considerably from State to State, reflecting the level of alcoholism program development within each State and the experience and expertise of the designated State agencies. Those States that already have an operating alcoholism treatment and rehabilitation network will utilize a major portion of their formula grant funds for direct services at the community level. The States which are in the beginning stages of alcoholism program development are devoting funds to a deeper survey of need, coordination, community organization, and program planning.

Many states consider FY 1974 as the time for major revisions in their plans. At the present time the previously projected programs are becoming fully operational and to the point of evaluation; studies initiated are being completed and results analyzed; and staff capability is being developed throughout the States and communities. During FY 1975, the Institute will continue to work with the States to improve and update their State plans.

Community Assistance Programs

Community Assistance funds are made available to support community efforts to develop and conduct comprehensive health, training, and planning programs for the treatment of problem drinking and alcoholism. Such support helps cover initial salary costs of professional and technical personnel providing comprehensive alcoholism services and initiation and development of new service programs or other specialized programs and activities.

Comprehensive Treatment Programs

NIAAA has funded a total of 46 comprehensive staffing programs. During FY 1973, 31 comprehensive staffing programs were awarded continuation grants for a total of $7,746,000. Thirteen of the remaining 15 programs were also active as of June 30, 1972, with renewal dates of September 1, 1973, or later and will receive continuation funding during FY 1974. One comprehensive program was not operational as of June 30, 1973 because of internal grantee problems.

It is anticipated that during FY 1974 the comprehensive staffing programs will provide the capability for treatment and rehabilitation services in areas where nearly 400,000 alcoholic people live. Each of the comprehensive programs provides a required range of services, including inpatient, outpatient, intermediate, and emergency care, as well as consultation and education services. The programs are in communities serving a variety of populations and include alternative approaches to the treatment and care of alcoholic people.

Of the 46 centers supported by NIAAA in FY 1973, 26 were components of Community Mental Health Centers and 14 were closely affiliated with Community Mental Health Centers. The remaining six alcoholism centers were free-standing. Twenty-three of the comprehensive programs serve designated poverty areas and, therefore, receive preferential poverty funding.

Other Community Service Grants

Support was also provided in FY 1973 for the continuation of five direct service grants, totaling $1,034,656. (A direct service grant is for the purpose of demonstrating various programs or methods that can be used by a community to initiate, extend or provide for its delivery system.)

Technical Assistance Activities

An important function of the Community Assistance Programs in FY 1973 was the provision of technical assistance in a variety of program skills and activities involved in meeting alcohol-related problems. Such assistance was rendered to requesting public and private agencies, communities and to program sites funded in whole or in part by the Institute.

Monitoring and Evaluation Activities

Essential to the proper use of public funds by the Institute for the development of alcoholism programs has been a necessity to implement strong evaluation and monitoring functions in Community Assistance Programs to insure that funds are efficiently expended. A feedback mechanism was created to enable NIAAA management to measure progress toward national objectives and to provide data for local program evaluation. Deficiencies noted in the evaluation procedure are brought to the attention of the individual programs along with recommendations for their correction.

As part of the monitoring effort, extensive on-site evaluations were made to a substantial number of comprehensive programs. Cost analysis studies were made at selected centers funded by the Institute.

Activities within the comprehensive programs led to new and expanded approaches to alcoholism services, including the development of volunteer programs, the establishment of a foster home system as part of transitional care, the creation of a nonprofit corporation to provide employment in an economically depressed area, the development of occupational alcoholism service units and outreach efforts to high-risk special population groups.

DIVISION OF SPECIAL TREATMENT AND REHABILITATION PROGRAMS

The National Institute on Alcohol Abuse and Alcoholism has collaborated with various Federal, State, and local agencies in developing programs to reduce and prevent alcohol-related problems in special population groups. For example, some collaborative programs provide treatment services specifically designed for drinking drivers, American Indians, chronic drunkenness offenders, low income persons, alcoholic employees of government and industry, Alaskan natives, Blacks, Spanish-Americans, the criminal justice population, women, youth and migrant farm laborers.

Occupational Alcoholism Programs

Through a variety of efforts, occupational alcoholism activities have been concerned with promulgating conceptual models for industrial occupational alcoholism programs and stimulating their implementation and evaluation. NIAAA funded 10 grants in FY 1973 aimed at the development of treatment concepts appropriate and acceptable to employed persons, and consistent with the status and dignity that employment implies. In response to this need, the "troubled employee" approach was developed. Empirical research has shown that close to 50% of all employee problems are related to alcohol use and, by setting up alcoholism facilities alongside of and analogous to those physical health resources already available to most industrial organizations, the health care system can meet the needs of the total person-medical, personal, and behavioral.

State Occupational Staffing Program

In mid-July, 1972, an initial training session was concluded for more than 100 Occupational Consultants. The program was based on the "troubled employee" approach of identifying or treatment employed persons suffering from alcohol abuse and alcoholism.

In "troubled employee" programs, supervisors are trained to identify those employees who show impaired job performance. When such impairment persists, the supervisor directs the employee to an Employee Assistance Service where a trained interviewer ascertains the cause(s) of impaired performance and directs the employee to the appropriate community-based agency or agencies for help or treatment.

Under grants, 49 of the States, the District of Columbia and the Virgin Islands were provided with two trained Occupational Consultants each. This program constitutes a major step by

Government, Federal and State in dealing with alcoholism in the work force of the nation. The consultants are qualified to create programs of Management Control Systems for business, industry, and State and local government, in cooperation with management and employee organizations.

With nearly 90 million persons employed by thousands of employers, the magnitude of the task is enormous and particularly difficult because of traditional indifference to the problem of alcoholism among employed people.

The major effort of the NIAAA staff and the Occupational Consultants of the States and the District of Columbia was directed to:

- Informing management and labor of the benefits--human and monetary-- of these programs to employees and employers.

- Providing consultative support to management and labor in creating such programs for early identification and treatment of employees suffering from alcoholism. While the task is far from complete, an encouraging start was made.

Changes which occurred during FY 1973 in the attitude of management and labor leadership has been encouraging in both private enterprise and Government. There is reason to believe that this trend will increase as knowledge of the success of modern, well-conceived occupational programs becomes more widespread.

Grants to 49 States, the District of Columbia and the Virgin Islands, initially funded in FY 1972, were continued in FY 1973 with $2,591,511 in funds. Ten industrial programs, initially funded in FY 1972, were refunded in FY 1973 for $1,283,446 and the programs were designed to develop evaluative data on a variety of aspects of occupational alcoholism. The total Occupational Program was funded at a level of $3,874,957 for FY 1973.

Statistical data on programs created during FY 1973 were not complete at the time this report was completed. However, in 38 States on which information was available:

- 262 new programs were implemented.

- A work force of 2,741,738 was covered by the programs.

In the public sector, these State governments implemented programs covering their employees:

Connecticut
Delaware
Georgia
Illinois
Maryland
Minnesota
New Jersey
New Mexico
New York
Tennessee
Texas
Utah
Washington

Several other States and the District of Columbia were very near to implementing programs at the close of the Fiscal Year.

Federal Employees Alcoholism Program

During FY 1973, site visits for consultation were provided to 72 Federal civilian and military installations in 29 States, Europe and the Far East.

Civilian Employees - While the Civil Service Commission (under Public Law 91-616) is responsible for developing programs in civilian Federal agencies in cooperation with those agencies, NIAAA provides, on request, technical consultative assistance to the Commission and to individual Federal agencies. Consultation has covered the design and structuring of programs, and their progress in meeting requirements of the particular work force, and the development and design of training materials for staff employed in the various programs.

Military Employees - In compliance with Public Law 92-129, Title V, Section 501, the Secretary of Defense commenced the establishment of programs for the identification and treatment of members of the Armed Forces and civilian employees of the Department of Defense. (On request, the NIAAA provides consultative support to Armed Services in the creation and evaluation of their programs. Service programs vary in many particulars in order to meet the circumstances in which uniformed and civilian employees work and live. Requests from the Department of the Army and Navy were so extensive that arrangements are being made to provide reimbursement for services to be performed during FY 1974.)

The NIAAA has also continued to work closely with private, nonprofit institutions and organizations concerned with alcoholism among working people, such as the Alcohol and Drug Problems Association of North American and the National Council on Alcoholism.

Special Projects

The Drinking Driver Program

Among these special treatment and rehabilitation programs is a 10-point interagency collaborative program with the National Highway Traffic Safety Administration (NHTSA) of the Department of Transportation and HEW aimed at reducing the number of deaths and injuries caused by drinking drivers. Under this agreement, NIAAA provides consultation and assistance in the development of the DOT community-oriented Alcohol Safety Action Projects (ASAP) and support for treatment and rehabilitation of problem drinking drivers identified in ASAP operations. In other areas of cooperation, NIAAA's information and education program on the use and misuse of alcohol is coordinated with DOT's information campaign on drinking and driving, and shares research findings.

NIAAA approved for funding projects in 26 of the ASAP sites as well as in communities outside ASAP sites with substantial drinking driving problems. With the utilization of DOT "402" funds, "mini-ASAP" programs were developed. During FY 1973, 19 Drinking Driver grants were received and reviewed for a total of $3,622,609, of which nine, for $1,767,755, were approved but not funded. Sixteen programs, initiated in FY 1972, were continued in FY 1973 for $1,999,599.

The NIAAA special demonstration grants within the Drinking Driver program focus both on meeting the needs of problem drinkers and on the future development of comprehensive treatment and rehabilitation services for all alcoholic persons in the community. There are a number of special concerns and directions resulting from the development of the Drinking Driver program. For example, an effort is being made to utilize the highway safety efforts of the Department of Transportation to identify candidates for treatment early in the course of their problems with alcohol abuse. The program also seeks to change the attitudes of police, judges, and probation officers toward accepting the concept of alcoholism as an illness and taking responsibility for directing the drinking driver to treatment.

The development of a cooperative working relationship between NHTSA and NIAAA and the enforcement and the health care systems within each of the ASAP community sites is an example of the way in which States may implement the Uniform Alcoholism and Intoxication Treatment Act. The emphasis becomes one of reeducation, treatment, and rehabilitation rather than the traditional one of imposing fines, jail sentences, or other punishments.

The American Indian Program

The primary goal of the American Indian/Alaska Native Programs is to develop effective alcoholism treatment and rehabilitation services for the American Indian/Alaskan Native at the community level, i.e., reservations, rural areas and large cities. The Program is a special initiative of the Institute, rather than a legislative mandate, in recognition of the pandemic nature of the problem.

Programs are supported for education and training of Indian/ Alaskan Native people and for innovative community services. A major emphasis is on the importance of giving Indian and Alaskan Native people the authority and resources to identify and solve their problems of alcohol abuse and alcoholism themselves.

In FY 1973, the Institute funded 140 Indian/Alaskan Native alcoholism programs for $6,808,844. Ninety-six of the programs received continuation grants; 44 were new starts, a special initiative for Alaska. The Alaskan Native "mini-grant" programs are composed of one-year grants of $5,000 to $10,000 to provide for the establishment of village prevention and treatment programs.

In addition to the above-mentioned 140 alcoholism programs, one Indian grant program was supported for $162,500 by means of an integrated grant award. Two programs, initially funded by NIAAA in FY 1972, will not begin refunding until FY 1974 because of late starts. Two additional grant projects transferred from OEO will not require refunding by NIAAA due to the renewal date of the projects.

During Fiscal Year 1973, 49 grant applications were received, of which 37 were approved but unfunded for $4,252,210.

In order to be fully responsive to needs associated with American Indian/Alaskan Native alcohol problems, NIAAA also has been cooperating with the Department of Health, Education, and Welfare Indian Health Services and other Federal Agencies that are directly servicing the American Indian/Alaskan Native population.

The Community Alcoholism Services Poverty Program

The intent of this program is to support special projects that demonstrate how a variety of services can be made available, and be effectively utilized, by the poor alcoholic person and his family. In a broader context, it is intended to demonstrate that the poor can be integrated into existing health and social service systems. This program was initiated officially in May, 1972, concurrent with the transfer of 185 Alcoholism Recovery Projects from the Office of Economic Opportunity to the National Institute on Alcohol Abuse and Alcoholism.

In addition to the 185 service programs, six Alcoholism Counselor Training programs were also transferred to NIAAA from the Office of Economic Opportunity.

A contract between the National Council on Alcoholism (NCA) and the Office of Economic Opportunity to provide technical assistance and monitoring to the service programs was transferred to NIAAA in July, 1972. This contract is valued at $305,629.

During FY 1973, all but 27 of the transferred projects were funded at a level of $9,364,562. The six training programs were approved for continued support for an additional year at a level of $2,116,475. In addition, two projects, initially reviewed and funded by NIAAA during FY 1972, were continued and refunded in FY 1973 in the amount of $165,338. Twenty new grant applications were received, seven of which were approved but unfunded. The total amount of the approved but unfunded applications was $692,754.

Other Special Population Groups

NIAAA is concerned with special population groups for whom specially arranged or developed services can have significant impact on the problem of alcohol abuse and alcoholism. Spanish-speaking Americans, as well as offenders within the correctional system, women and young adults are among the population groups for whom categorical programs do not yet exist within the NIAAA.

While applications for these populations were never actively solicited, a total of 11 were received in FY 1972, seven of which were funded at an annual total of $682,144. Five of the programs were refunded in FY 1973 at a cost of $516,000. In the first review cycle of FY 1973, nine applications were received and three approved at Council level for an annual total of $488,277, unfunded. In the second review cycle of FY 1973, there were 19 applications reviewed, of which the Initial Review Group (IRG) recommended eight for approval at an annual cost of $1,033,820. None of the new projects reviewed in FY 1973 were funded.

DIVISION OF PREVENTION

The Division of Prevention became operational in October, 1972. Prevention and control of alcohol abuse and alcoholism, the objective of this Division, is one of the two major objectives of the

Institute. The other is to make available treatment and rehabilitation services to alcoholic people and problem drinkers when and where needed. Prevention and control of alcohol abuse and alcoholism is a vital program element and primary goal of a national social/health policy and strategy.

The Division of Prevention has responsibility for the prevention and control of alcohol abuse and alcoholism under P.L. 91-616, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970. In addition, the Institute and the Division of Prevention have been provided the first opportunity by P.L. 91-616 to carry out the full intent of the 22nd Amendment to the Constitution since enactment in 1933.

The Division includes the following: Youth Education, Community Prevention, the National Center for Alcohol Education, the National Clearinghouse for Alcohol Information, and Extramural Training.

These areas develop, implement and evaluate alcohol abuse and alcoholism prevention programs and develop qualified personnel to meet the needs of a heterogeneous American society in which more than 100 million Americans are drinkers or users of alcoholic beverages.

A total of $3,647,136 was expended for prevention grants and contracts. The Division awarded a total of eight grants amounting to $1,018,961, five contracts amounting to $668,175, and a contract amounting to $1,960,000 for the administration of the National Center for Alcohol Education.

Youth Education

The Youth Education Program directs its efforts primarily at the nation's youth who represent a major segment of the population, and their parents from whom attitudes and lifestyle practices, important to alcohol abuse and prevention, are first learned and developed.

During FY 1973, six grants were awarded in the amount of $417,486 to develop pilot approaches relevant to meeting the needs of young people in a variety of settings, and four contracts amounting to $593,175. The grants were for:

- NATIONAL YMCA ALCOHOL EDUCATION PROJECT

  The National YMCA Alcohol Education Project, designed for students in grades 4-6 and their parents, utilizes a YMCA in Akron, Ohio, to develop a model program for utilization by Y's in the national organization. The amount of this grant was $90,392.

- PEER GROUP DEMONSTRATION

  Another project utilizing other than the traditional school setting but complementary to the classroom approach, is the "Peer Group" demonstration project. This approach utilizes older students to work with younger students (college with high school; high school with junior high and elementary), in an inner city area of Philadelphia, Pennsylvania.

The amount of this grant was $124,727.

- SCHOOL/COMMUNITY PROJECT FOR DEVELOPMENT OF GUIDES FOR LIVING AND WORKING TOGETHER

  In a rural setting, Holland Patent, New York, a school/community project, involving school-age youth and parents seeks to develop guides for living and working together and meet the growth and development needs of young people in this setting. The project incorporates those elements of growth, development and learning important to equip young people to be able to participate in the system. Such areas as attitude development, socialization, self-awareness, value clarification, decision-making and coping skills are stressed. This grant amounted to $50,545.

- VISUAL AIDS DEVELOPMENT TO STIMULATE DISCUSSION AMONG YOUTH

  The fourth grant was for a project applicable to both the traditional and non-traditional settings for learning and calls for the development of visual aids designed to elicit and stimulate discussion among youth. The grant was made to the University of Michigan, School of Public Health for $23,883.

- MASS MEDIA DETERMINATION IN RELATION TO PARENT AND PEER INFLUENCE

  Other special projects relevant to the prevention of alcohol abuse and alcoholism include a study to determine how mass media works in relation to parent and peer influence, particularly in the socialization process and the communications patterns between parents and adolescents. This study, part of a larger study, is at the Department of Journalism, University of Michigan. This grant award amounted to $28,295.

- CHILDREN OF ALCOHOLICS

  This study focuses on children of alcoholics, a high risk group with special prevention needs, to determine ways in which they are able to cope with living practices and stress in their lifestyles. The amount of the grant was $99,644.

Contracts awarded within the scope of the Youth Education Program involved:

- A MODEL LEARNING SYSTEM IN ALCOHOL ABUSE AND ALCOHOLISM PREVENTION FOR KINDERGARTEN LEVEL

  In this environment, the more traditional locus of learning, the school, a model learning system for grades kindergarten through 12 was initiated. This contract amounted to $223,375.

- THE PARENTS AS A MODEL FOR CHILDREN--COLLABORATIVE PROGRAM WITH NATIONAL CONGRESS OF PARENTS AND TEACHERS

  Another national citizens voluntary organization with whom a collaborative program was developed is the National Congress of Parents and Teachers. This program was continued in 1973 with greater emphasis on the role of the parent as a model for children in their total learning experience. This contract amounted to $70,000.

- DRINKING BEHAVIOR OF HIGH SCHOOL STUDENTS

Experiences of the last decade, pinpointed more recently by the report of the National Commission on Marihuana and Drug Abuse, showed that alcohol was the most abused drugs among adults and teenagers in this country. A survey had been initiated to obtain baseline data on drinking behavior among junior and senior high school students and to obtain data important to program development among teenagers, such as circumstances of teenage drinking, attitudes and contexts concerning alcohol use and abuse, and the drinking history of respondents. This contract award was for $194,800.

- ASSESSMENT OF CURRICULUM MATERIALS AND TEACHER TRAINING

Other projects included a study to assess the kinds of curriculum materials currently available for alcohol information and the availability and kinds of teacher-training classroom teachers receive. The assessment revealed a dearth of both. This contract was for $105,000.

Community Prevention

During FY 1973, two grants were awarded in the amount of $601,475 and one contract amounting to $75,000. Developing and evolving a national health policy and strategy must provide opportunity for people, participants and beneficiaries, to become involved. In terms of the prevention and utilization of resources, people participation and involvement is essential. The two grants and one contract in Community Prevention involved:

- U.S. JAYCEES, NATIONWIDE EDUCATIONAL PROGRAM

To develop the broad-based citizen's awareness of alcohol abuse and alcoholism programs and gain citizen participation, the cooperative, nationwide educational program, begun in 1972 with the U.S. Jaycees, was continued in 1973. The U.S. Jaycees, through chapters and membership, is involving other groups from the private and public sectors in communities. This grant award was for $544,850.

- SMALL BUSINESS --LEVEL OF AWARENESS AND NEEDS TO UTILIZE ALCOHOL ABUSE, ALCOHOLISM PREVENTION PROGRAMS

The small business work setting offers opportunity for early identification and prevention of social health problems. Utilizing business techniques, this potentially untapped market will be assessed to determine the level of awareness, understanding, readiness, and needs to utilize alcohol abuse and alcoholism prevention programs. This project is being covered in a southeast section of the country, focusing on the small business sector of the economy, which accounts for about 40% of job opportunities. This grant award amounted to $56,625.

- VOLUNTARY CITIZENS GROUPS TO ADDRESS EFFECTIVE RESOLUTION TO ALCOHOL ABUSE THROUGH EDUCATION

  In 1973, a new cooperative program was initiated with the Education Commission of the States (ECS), located in Denver, The program activities were complemented and strengthened by volunteer citizen groups. The Commission's membership comprised the Governor, legislators and citizens from each state. The purpose of ECS was to provide a mechanism for States to work together on addressing common issues. In this instance, the purpose was to bring about a practical and effective resolution to alcohol abuse and alcoholism through education. The contractor developed a plan to create an understanding of alcohol abuse prevention education needs among selected systems, including schools, higher education, policy making, health care, voluntary and official agencies to implement a national alcohol abuse prevention program. The cost of this contract was $75,000.

National Center for Alcohol Education

During 1973, the Institute sponsored the establishment of a National Center for Alcohol Education. The primary goal of the Center was the creation of an exemplary education center where leaders in a variety of fields--business executives, mayors, governors and health providers working in the alcohol field--may come together to pursue the solving of issues and develop more effective approaches to alcohol abuse and alcoholism. It is also to serve as a model for the development of regional centers for alcohol education.

Other components of the Center include:

- An Experimental Education Laboratory for educating alcoholism program practitioners and educators.

- A Resident Scholar Program in which distinguished behavioral experts will develop scholarship and multi-disciplined professional expertise in the field.

- A Resident Fellowship Program for recently graduated behavioral scientists.

The Center provided the Institute with a perpetual flow of current, factual baseline data from a wide spectrum of interests in the private and public sectors. These will enable the Center to mount a comprehensive survey of education and training programs for private and public resources related to the delivery of services in alcohol abuse and alcoholism. The expected results of this survey will identify and highlight effective program components gaps and needs toward which future Federal initiatives should be directed, for example, in terms of National Health Policy and National Health Insurance.

The function of the Center was administered and performed under contract during FY 1973 in the amount of $1,960,000.

National Clearinghouse for Alcohol Information (NCALI)

The Clearinghouse, which was established in 1972, serves as the national focal point for the collection and dissemination of technical and public information on alcohol abuse and alcoholism. Support services are provided by General Electric which was awarded a $993,000 1-year contract by NIAAA. This contract was renewed in FY 1973 for $1,897,700. The Clearinghouse disseminates a wide range of information prepared for medical and scientific personnel and for the public at large. Among the many activities of the Clearinghouse are the acquisition and processing of various materials on alcohol and related topics; establishment of a materials repository and library; compilation and indexing of a source availability list; production of a guide to selected technical documents; utilization of automated data processing systems; replying to public inquiries and requests; distribution of documents; publishing a NCALI bulletin and a quarterly newsletter; and preparation of directories of Federally-supported alcoholism programs. In addition, standard and nonstandard responses, as appropriate, will be mailed to the millions of Americans who request information as a result of the advertising campaign.

The Division of Prevention recently undertook the monitoring of the National Clearinghouse for Alcohol Information contract and has also utilized this important element of the Institute's program to facilitate the sharing of prevention and other relevant data with a variety of groups and organizations at National, State and community levels.

During FY 1974, the Institute will continue those activities initiated in FY 1972 and FY 1973. The activities of the National Clearinghouse on Alcohol Information will be closely evaluated, realigned, and refined in order to improve and enhance the distribution of alcohol information. With the expanding nature of the Federal alcoholism effort and recognition of alcoholism as America's largest "hidden" health problem, the Clearinghouse will play an important role in helping to fulfill the goals and objectives of the NIAAA.

Training

The primary task of the Institute's training program is to effect a change in attitudes toward alcoholic people and problem drinkers through the development of qualified personnel in the areas of prevention, treatment, and rehabilitation. The development of personnel to combat alcoholism has had a brief history, compared to other training efforts in the health field. In addition, alcoholic people have problems that cannot be compared to others in need of health care. The alcohol abuser has to a considerable extent been avoided by health care practitioners who do not wish to provide treatment and who justify such nontreatment on the grounds that alcoholism is a moral rather than a medical problem or in the belief that it is untreatable. This negative attitude is characteristic, not only of some health practitioners, but of institutions of higher learning, community agencies, and State and local organizations.

In order to change these basic attitudes, the NIAAA during Fiscal Year 1973 increased the supply and improved the quality of training of professionals and paraprofessionals. This was achieved by facilitating the inclusion of alcoholism training through grant support in such professional fields as medicine, social work, public health, psychiatry and psychology. The importance of paraprofessionals and lay workers to alcohol abuse and alcoholism services as well as to the national health care system was enhanced by the development of a new career program established by NIAAA staff.

The Institute was able to fund 59 training grants amounting to $4,979,000 and three fellowships for $18,000 or a total of $4,997,000. Of the 59 grants, 12 were new grants, five competing renewals and 42 noncompeting renewals.

The 12 new training programs awarded in FY 1973 were short-term, low-cost, and had reasonable expectation of partial funding from other sources. Almost all of the new programs had strong ties with State or community organizations; they were broad-based, with strong community support, and it is anticipated that they will continue to be supported in the community with the termination of Federal funding.

Two of the new programs had clearly defined ethnic targets, the North American Indian and the Multidisciplinary program based in Puerto Rico for the Puerto Rican population.

Two consortium programs embrace a number of organizations in the community under a single umbrella and one new program is for training recovered alcoholic people as counselors in an inpatient clinic which has very strong community support and which will, without any doubt, be supported by the community when Federal support terminates. The emphasis here was not on traditional support programs in terms of disciplines and educational levels. The Institute premise is that the development of manpower should be for definite programs needing definite numbers of personnel with specific kinds of training.

During FY 1975 the Institute will continue to support projects started in prior years.

DIVISION OF RESEARCH

Extramural Research

The primary goal of the Institute's Extramural Research is to foster the development of effective methods of preventing and treating alcoholism and alcohol abuse. To achieve this objective, the Institute supports a broad program of research on etiology, diagnosis, treatment, and prevention of alcoholism.

Since alcoholism is the product of a complex interaction of biological, psychological, and social factors, hope for developing a better understanding of its causes, natural history, and treatment lies in a wide range of research in all relevant disciplines. The NIAAA encourages and supports basic and applied investigations in universities, medical schools, and other institutions. Projects are supported to develop and evaluate new techniques, approaches, and methods for the treatment and prevention of alcoholism and the rehabilitation of alcoholic persons and problem drinkers.

During FY 1973, Extramural Research received 182 applications for research grants for projects on a wide variety of problems associated with the use and abuse of alcohol. This was an increase of 100 percent over the number of applications received in the first year the Institute was established. Seventy-eight applications were recommended for approval and these were added to approved and unfunded applications carried over from FY 1972. Thus, a total of 103 new and competing renewal applications were judged to have scientific merit and be worthy of funding during FY 1973.

At the close of FY 1973, the Extramural Research grants program had funded 10 new or competing renewal applications, 78 noncompeting renewal applications, a chairman's grant for $60,000, and several contracts and career development awards for a total of 102 grants and contracts funded for $6,472,000.

In addition to the 102 grants and contracts were 23 projects designated as health initiative projects in the amount of $2,183,045, specifically focusing on health care services, new techniques for improving the productivity of the medical system, and innovative projects in alcoholism research.

Projects regarding treatment and rehabilitation are focused on socio-psychological approaches to the treatment of alcoholism and the medical management of the alcoholic patient. Research continues to be conducted on the family having an alcoholic member. These studies will report on communication patterns within such families; the function of alcohol and the role played by the alcoholic person; and methods used by families to cope with alcoholism. One study which received initial funding last year sought to evaluate two groups of women-- members of a voluntary organization and members of a church-- with respect to dealing with alcoholism in the family. The research is still in the preliminary stage; however, early findings suggest that parish women exhibit greater stability in terms of length of time living in the area, broad social networkds of kin and friendships, more religious activity and professed greater faith. A collateral, provocative, finding indicates that wives of alcoholic spouses have had no meaningful communciation with them since the inception of the marriage.

Additional projects to study international patterns between married couples having an alcoholic spouse and the development of therapy procedures, patterns of alcohol use in rural communities, and the development of differential treatment for alcoholic subgroups were recommended for approval and await funding.

Under the guidelines of the health initiative program, grants were awarded for the psychological and medical treatment of alcoholic patients, for the assessment of drinking problems and practices of urban American Indians, corss-cultural studies of problem drinking in Irish-Americans, the identification of employed alcoholic persons and their supervisiors' attitudes toward their drinking problems and for the drinking driver problem. In a few instances, preliminary findings were presented at the NIAAA Annual Conference.

Under the aegis of the regular grant program, 88 projects were funded for a total of $5,433,000. Grants were awarded for basic and applied studies on behavioral and biomedical aspects of the effects of alcohol abuse, treatment and rehabilitation, prevention and on the etiology of alcoholism.

Grants for University-Based Centers

During FY 1973, funding was continued for three grants awarded to university medical schools for the support of multidisciplinary research programs. As initially conceived, the centers were established for the purpose of conducting research from a variety of perspectives including psychiatry, psychology, biochemistry and physiology, and to recruit scientists into alcoholism research. A number of centers were established, reaching a maximum of seven in FY 1969. As interest in alcoholism research became more widespread, it was found that the direct stimulation and recruitment of qualified researchers through the support of Centers was less practical; consequently, funds were increasingly provided for support of individual projects. In the future, researchers currently supported by funds from Center grants will be encouraged to submit applications on an individual basis.

Bio-Medical Studies

The largest number of grants and dollars were awarded for basic and applied research into biological aspects of alcohol effects. Interest continues in the etiology of liver cirrhosis and other alcohol-related diseases, and the study of the withdrawal syndrome and its treatment. There is considerable research interest in identifying the mechanisms and enzymes responsible for the metabolism of alcohol. Several research groups are currently attacking the problem and making determinations as to whether alcohol is metabolized solely by two or three enzymes. Recently, the Institute sponsored a scientific meeting bringing together the world's leading authorities to discuss this research area, to chart new research directions and to avoid needless duplication of research efforts. The findings from relevant studies in this area should bear importantly on the development of methods for enhancing the efficiency of eliminating alcohol from the body and for understanding the mechanism of liver pathology associated with alcohol abuse. In this connection, one recent study suggested the possibility of experimental induction alcoholic hepatitis.

Along similar lines, there is continuing interest in the development of an agent which could block the effect of alcohol on the brain. Subsequent to earlier, more optimistic reports, it was found that neurochemical intervention of alcohol's intoxicating effects is not easily achieved. The problem is a difficult one but one which would pay off well if a breakthrough were to be obtained. A substance which would reduce or prohibit the effects of alcohol on the brain would be of considerable value in treatment as well as during the rehabilitation process.

Biomedical scientists have recently demonstrated an association between chronic alcohol abuse by mothers and birth defects of their children. Although the research included only a small number of children, the Institute is vitally interested in investigating the phenomenon and is actively stimulating research on this subject. Studies should be conducted to determine the prevalence, type and severity of birth defects, their permanence or reversibility and susceptibility to treatment, possible implication of paternal alcoholism, and the possible induced predisposition to alcoholism in later years among children of alcoholic parents. The potential findings of a program of research in this subject area would have far-reaching implications for early identification and treatment of children of alcoholic parents and primary prevention of alcoholism.

Studies of Treatment

The Extramural Research continues to emphasize the need for research on treatment methods. The number of clinical research projects funded by the Branch has doubled since the Institute was established, and now accounts for 27% of research grants funded in FY 1973. From another perspective, the increasing redirection of the research grant program is reflected by the shifting emphasis to applied research. For instance, in FY 1970, the last fiscal year prior to the establishment of the Institute, the percentage of basic and applied projects were 70 and 30, respectively. For FY 1973 the percentages were 59 and 41, respectively.

New Projects

Fiscal Year 1973 was a year of limited fund availability and, consequently, only a small number of new projects having the highest Institute priority were funded. Four projects were concerned with treatment efforts; the use of halfway houses for American Indians, identification and treatment of alcoholic women, the analysis of alcoholism treatment networks for enhancing the delivery of services to alcoholic patients and the investigation of a chemical substance having possible anti-alcohol effects.

Other Activities

An important program activity of Extramural Research is to identify and stimulate research in underdeveloped or promising areas. In addition, Extramural Research has the responsibility of facilitating the dissemination of new research findings in order to enhance their rapid utilization by the therapeutic community and to provide a forum for researchers to communicate with other scientists on problems of mutual interest.

Collaborative Research

In addition to the above activities, research was conducted in collaboration with non-Institute scientists. Results from two such studies were published during the year while a third manuscript was submitted for publication. One study was concerned with the identification of personality characteristics of alcoholic patients, the other was addressed to the problem of identifying alcoholic persons by means of a national driver register. A third project investigated the records of single-car fatal accidents and associated epidemiological factors.

Intramural Research

Laboratory of Alcohol Research

In addition to grant support of research investigations, the Institute operates its own research activities. The Intramural Laboratory of Alcohol Research is located at Saint Elizabeths Hospital, Washington, D.C. The laboratory program is focused upon an interdisciplinary analysis of the basic biological and behavioral correlates of alcoholism in man and examination of the development of alcohol addiction in experimental animals and the development of new treatment modalities for treating alcoholic people.

The program has three main thrusts:

The Clinical Program is engaged in studies of behavioral aspects of alcoholism, particularly as it relates to interaction within the family that uses and abuses alcohol and in the development of therapeutic procedures.

The Biochemistry Program conducts research into the mechanisms of importance in the metabolism of alcohol and on other bodily functions associated with alcohol ingestion abuse and withdrawal.

The Behavior Program is engaged in biobehavioral research on humans and experimental animals directed toward the clarification and understanding of the addictive process in alcoholism and the effects of alcohol ingestion.

In addition to research activities, staff members are actively engaged in a number of educational activities at major medical schools and in the training of scientists in its own laboratories.

Basic research on alcohol metabolism is also supported, through direct allocation to investigators in the NIMH Division of Special Mental Health Programs.

During FY 1973, personnel costs for the Laboratory of Alcohol Research were $326,043. Other direct operations for the Laboratory of Alcohol Research were $107,113. Maintenance support on the facilities, clinical research ward and animal laboratories occupied by NIAAA at Saint Elizabeths Hospital amounted to $18,000. In addition, NIAAA contributed $60,000 toward the direct operation of the Metabolic Research Program of the NIMH Division of Special Mental Health Programs. Total expenditures for intramural research during FY 1973 totaled $511,156.

During FY 1973, staff of the Laboratory of Alcohol Research published a total of 18 reports in scientific journals and made 14 presentations at scientific meetings.

During FY 1975, NIAAA will continue to support research activities currently underway. In addition, however, many new projects will be developed and supported in such areas as clinical research, prevention and education, behavioral and psychological studies, alcohol and driving, the physiological effects of alcohol, and research demonstration contracts.

HEALTH INITIATIVE PROGRAM

As a result of the President's Health Initiative Message of February, 1971, NIAAA awarded, toward the end of FY 1972, 51 grants in the amount of $7,033,222 of which 31 were in the research area and 20 in the demonstration area. These grants and contracts focused on research, on new techniques of improving the productivity of our medical system with emphasis on pilot experimental and demonstration projects. They disseminated the results and encouraged the health industry and medical professionals to bring these techniques and results to effective use.

As the goals and preliminary results of this health initiative program were considered and found to show sufficient promise, NIAAA awarded 23 project grants in FY 1973 in the amount o $2,183,045 to be designated as health initiative projects. These projects specifically focused on health care services, new techniques for improving the productivity of our medical system and innovative projects in alcoholism research.

Under the guidelines of the health initiative program, grants were awarded, for instance, for the psychological and the medical treatment of alcoholic patients, for the assessment of drinking problems and practices of urban American Indians, cross-cultural studies of problem drinking in Irish-Americans, the identification of employed alcoholic persons and their supervisor's attitude toward their drinking problems and for the drinking driver problem. These projects have been underway for only one year and most projects are still in the data collection stage.

HEALTH INSURANCE COVERAGE FOR ALCOHOLISM

Health insurance mechanisms for conditions such as alcoholism have not developed as quickly nor fared as well as those mechanisms for purely physical conditions. In the past, coverage for the treatment of alcoholism has generally been excluded from health insurance. In a recent examination by NIAAA, the alcoholism coverage provided by various forms of health insurance in the United States revealed a spectrum of widely differing policy benefits, with alcoholism frequently excluded.

NIAAA believes that coverage for alcoholism and related health problems should be an accepted and routine feature of physican and/or mental conditions that health care facilities are expected to treat. Health insurance carriers should cover alcoholism as they already cover various aspects of care related to illnesses such as heart disease, cancer, diabetes, etc.

NIAAA and the National Council on Alcoholism initiated in FY 1973 the development of a proposed benefit package designed to act as a guideline to carriers providing alcoholism coverage in health insurance plans. This proposed benefit package will be made available to all State alcohol authorities, employers, trade unions, and the insurance industry. Technical assistance will be provided to NCA by NIAAA staff, who will assist interested parties in modifying or redefining this package to suit their specific requirements.

As a result of further joint NIAAA/NCA efforts initiated during the Fiscal Year, extensive data on the costs of treating and caring for alcoholic persons should soon become available. Costs have been frequently used as an argument againest insurance coverage by both carriers and purchasers, despite the fact that treatment costs were not well known. The data currently being collected should ultimately provide valuable information to health insurance purchasers, labor unions, and insurance carriers, and should facilitate the design as well as the negotiation of alcoholism policy provisions.

At the beginning of FY 1973, the Institute defined and scheduled a two-year objective containing elements relating to standard-setting activities and other activities that bear on the eventual participation of the private group health insurance industry in the provision of benefits for the total spectrum of services appropriate to the treatment of alcoholism. This work began during FY 1974 and will be instrumental in clarifying many of the issues involved and will be of help in reducing current health insurance exclusions or limitations related to alcoholism.

Standards for facilities, staff, performance criteria, and costs for providing alcoholism treatment are poorly defined. In an effort to resolve this problem, NIAAA entered into a contract with the Joint Commission on Accreditation of Hospitals to provide expertise and technical assistance in the development of standards in these various areas.

A contract for personnel standards will also be awarded in FY 1974. Contracts are being awarded to develop a model cost accounting system, licensure requirements for State facilities, and cost data for benefits.

INTERNATIONAL ACTIVITIES

A recent Conference held by the United Nations Educational, Scientific, and Cultural Organization in Paris concluded that alcohol remains the number one drug problem in both developed and developing nations. Alcohol constitutes by far the most serious and devastating drug problem in terms of the number of people it destroys, the number of families it shatters, and the enormous economic toll it exacts.

International cooperation offers the invaluable opportunity of utilizing a variety of resources toward discussing common concerns and possible plans for alcoholism treatment and research. Through a network of mutual cooperation, NIAAA has pursued solutions to common problems by sharing available resources and learning from the experience of other countries.

During FY 1973, the Institute funded a variety of studies to stimulate and support multinational cooperation in undertaking basic and applied research concerning the causes of alcohol abuse and alcoholism and the most effective methods of combatting them.

PROGRAM COORDINATION

During Fiscal Year 1973, the Institute formulated the objectives and goals of Program Coordination and established a framework for its program. The objectives were:

- To effect optimum liaison, coordination, and evaluation of all Federal alcohol problem-related programs as a total integrated system.
- To serve as the focal point of all inter-agency agreements.
- To provide timely management information for decision-making to the Director and all Divisions, Branches, key staff and Regional Offices.
- To improve the efficiency, effectiveness and utilization of all resources.

Collaboration and Interaction with Other Agencies

Improved interaction among Federal programs was achieved as the Institute developed the capability of serving as a focal coordinating point through inter-agency agreements. Efforts were made to gain the cooperation and involvement of a number of other Federal agencies whose joint resources meet the needs of alcoholic people. These agreements provided for the collaborative utilization of each agency's resources as appropriate.

Inter-agency activities include:

- Department of Defense Alcohol Programs Activity

  Program activity was coordinated with the Department of the Army and the Department of the Navy under which NIAAA provides consulting support in the creation and evaluation of their programs. (Technical support provided by NIAAA is described in the Specail Treatment and Rehabilitation Programs section of this Report.)

- Department of Transportation Alcohol Safety Action Programs

  Coordinated effort between NIAAA and the National Highway Traffic Safety Administration (NHTSA) of the Department of Transportation served to accelerate the provision of services to the alcohol countermeasures program of that Department. A part of the support provided was technical source information and resource capability on the causes and consequences of abusive drinking. NHTSA reimbursed NIAAA in the amount of $100,000.

- Department of Transportation Public Education Campaign

  A cooperative survey effort was entered into by the National Highway Traffic Safety Administration (DOT) and NIAAA to determine, analyze, and evaluate the impact of the ongoing public education campaign concerning alcohol use and highway safety. NIAAA was reimbursed $50,000 of a total of $275,000 expended by NIAAA for a comprehensive survey/evaluation effort.

- Department of Labor Rehabilitation Research

An agreement was coordinated between the Manpower Administration of the Department of Labor and NIAAA for the rehabilitation of problem drinkers in the Baltimore area with the purpose of retaining them on the job. This agreement sought to integrate and coordinate the planning and funding of an alcoholism program of interest to both agencies. The goal was for both agencies to identify, explore and innovate techniques for bringing a higher quality of treatment services to a greater number of employed alcoholic people, as well as to research the development and results of such a program. The project was centered in an industrial employee assistance clinic in Baltimore. In FY 1973, a grant was awarded by the Labor Department to Johns Hopkins University amounting to approximately $252,000. Eighty percent of this amount, $201,363, was reimbursed to the Department of Labor by NIAAA. Funding for FY 1974 is being established on a 50/50 basis.

- Department of Justice Information Program

A collaborative agreement was negotiated by NIAAA with the Law Enforcement Assistance Administration (LEAA), of the Department of Justice, whereby 25,000 police chiefs and other law enforcement decision-makers received essential information on Alcohol and Health. NIAAA reimbursed the Justice Department in the amount of $750 for these services.

- Center for Disease Control Cooperative Education Program

An agreement was coordinated and negotiated between the Center for Disease Control, National Clearinghouse for Smoking and Health, and NIAAA to provide for inclusion of education on responsible use of alcohol within the program on smoking and health. The inclusion of an alcohol abuse and alcoholism component in the established program on prevention and control of cigarette smoking was of great help to NIAAA. In this way, alcohol education reached health professionals, students, voluntary groups, adults in various organizations, the military, special minority consumers and leadership in the mass media. The two programs reinforced each other in seeking to help people make better personal choices as to take-up, cessation, modification or control of smoking or alcoholic beverage use.

NIAAA provided $105,000 as reimbursement for its services to CDC which supported the effort with an additional $150,000. The joint effort amounted to $255,000.

Health Services Administration

Indian Health Service

Special Approach for the Indian Population

In 1969 an Indian Health Service Task Force on Alcoholism stated that "the majority of suicides, murders, accidental deaths, and injuries are associated with excessive drinking, as are many cases of infections, cirrhosis, and malnutrition. By far, the majority of arrests, fines, and imprisonments are the result of drinking (76 percent)." As a part of the President's message to the American Indians in July 1970, additional dollars were committed to begin development of needed special programs. These programs are carried out in cooperation with the NIAAA and have as objectives to increase public understanding and awareness of the problem; to change community attitudes; to support rehabilitation sources; to develop preventive programs for Indian youth; and to design education and training programs in the field of Indian alcoholism. The Institute's projects are designed to provide residential care, individual counseling, job placement, referral service, group therapy, Indian AA groups, recreation and self-government. The essential aspect of these projects, however, is the integration of Indian cultural patterns into the rehabilitative and learning processes by hiring Indian staff for programs, working through individual tribal mores, and emphasizing the Indian's image of himself.

The problem of alcohol abuse and alcoholism among Indian people requires excellent technical assistance in developing Indian alcoholism programs, training for Indian people, research into psycho-social variables of alcohol abuse and alcoholism among Indian people and sufficient funding, in order to deal effectively with this major health problem. The Indian Health Service and the NIAAA are in agreement on this approach together with the Indian community whose input helps clarify what the objectives should be, and who will assist in setting national policy with respect to the delivery of more effective alcoholism services to the American Indian and Alaskan Native communities.

NATIONAL INSTITUTES OF HEALTH

National Institute of Arthritis, Metabolism, and Digestive Diseases

NIAMDD grantee Dr. Frank L. Iber of Tufts University has shown that feeding alcoholic patients a diet containing medium-chain triglycerides (MCT), a man-made fat containing fatty acids of a special composition and molecular size, produces significant changes in the fatty acid composition of liver fats. The diet also increases previously depressed blood levels of albumin, which is usually considered to correlate with recovery of liver function in cirrhotic patients. Dr. Iber's findings suggest that the MCT diet may have a potential ameliorating effect on the liver damage.

Twenty-nine alcoholic patients, including 13 with cirrhosis, were fed a standard hospital diet containing conventional long-chain triglycerides (LCT diet). Following alcohol withdrawal, they were either continued on the LCT diet or fed a MCT diet for two weeks.

Substitution of the MCT diet for the standard diet induced several changes in liver fatty acid composition; shorter chain fatty acid content increased and long-chain fatty acids decreased. Low blood levels of albumin increased markedly in 16 of 22 patients when the MCT diet replaced the standard diet.

Another Institute grantee, at the University of California, Los Angeles, has been seeking the cause of breast enlargement which occurs frequently in male patients with alcoholic cirrhosis of the liver. Dr. Inder J. Chopra has found that the most striking difference between these individuals and normal males is the ratio of blood levels of an estrogenic hormone, estradiol, to blood levels of an androgenic hormone, testosterone. This ratio is nine to twelve times normal in the cirrhotic patients, probably due to failure by the damaged liver to carry out normal estrogen removal from the blood.

Because estrogen administration is known to cause breast enlargement, and androgen administration is known to inhibit mammary gland growth, this estrogen/androgen imbalance in male patients with alcoholic cirrhosis provides a setting favoring breast enlargement.

National Institutes of Health

National Institute of Arthritis, Metabolism, and Digestive Diseases

Alcoholism research at the National Institute of Arthritis, Metabolism, and Digestive Diseases (NIAMDD) is focused principally upon alcoholic cirrhosis of the liver, which claims the lives of some 32,000 Americans each year. New findings from recent research indicate that some cirrhotic patients may benefit from a dietary manipulation involving a novel type of fat, and that breast enlargement in male patients with alcoholic cirrhosis may result from a hormonal imbalance.

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Because estrogen administration is known to cause breast enlargement, and androgen administration is known to inhibit mammary gland growth, this estrogen/androgen imbalance in male patients with alcoholic cirrhosis provides a setting favoring breast enlargement.

SOCIAL AND REHABILITATION SERVICE

Community Services Administration

Social Services authorized by Titles I, IV-A, VI, X, XI, XIV and XVI are administered by the Community Services Administration. Within this broad spectrum of services for recipients and potential recipients of Aid to Families with Dependent Children (AFDC), Aid to the Aged, Blind and Disabled (AABD), Aid to the Permanent and Totally Disabled (APTD), and Supplemental Security Income (SSI) are those directed to solving or alleviating the problems brought on by alcoholism. It is estimated that the States will expend some $8,200,000 of Federal funds on recipients of AFDC and $35,900,000 on aged and disabled individuals in 1975 for services related to alcoholism.

Rehabilitation Services Administration

State rehabilitation agencies have been providing services for people with alcoholism for many years, but recently the expansion of services has accelerated until about 5% of the rehabilitants from all categories of disability have alcoholism as their major disabling condition. In fiscal year 1973, an estimated 17,800 alcoholic people were rehabilitated, a figure expected to rise to 18,800 in 1974, and to 20,000 in 1975.

Numerous special projects in alcoholism have been conducted by State rehabilitation agencies. In New Jersey, for example, the State agency works in close collaboration with private industry and organized labor in identifying and providing necessary services for employees whose jobs are endangered by alcohol abuse. Another project with a similar purpose is operated by the Wisconsin agency at De Paul Rehabilitation Hospital in Milwaukee. The Texas agency administers a project in El Paso to help the Chicano alcoholic, and another project in Dallas County to serve people being treated for alcoholism at Terrell State Hospital. Additional projects designed to serve alcoholic people are active in Alabama, Alaska, Connecticut, Florida, and Washington.

The Rehabilitation Services Administration has been operating in close cooperation with the National Institute on Alcohol Abuse and Alcoholism under the terms of a Memorandum of Agreement between the two agencies. Among their joint activities has been a national conference of the directors of State alcoholism and State vocational rehabilitation agencies conducted in March 1973 for the purpose of stimulating cooperative planning and programming in the area of alcoholism. Efforts are also being made to foster the integration of treatment and vocational rehabilitation services for alcoholic people.

Rehabilitation research and demonstrations--As in the case of other mental and personality disorders, rehabilitation of alcoholics is based upon development of a continuum of services including institutional programs, half-way houses, and other post-institutional facilities, transitional employment and appropriate placement and follow-up. Utilization of significant research results in the demonstration of techniques to facilitate community adjustment and successful employment maintenance are given special emphasis in the program.

Projects concerned with alcoholism have (1) developed methods of counseling, placement and follow-up of members of skid row populations; (2) conducted long-term follow-up studies of rehabilitated alcoholics; (3) studied career patterns of alcoholics to identify factors in successful vocational adjustment; (4) established a half-way house for homeless alcoholic men; (5) studied problems of alcoholic offenders; (6) developed two series of films on rehabilitation of alcoholics based on research results, one intended for public showing over television and the other series for professional training.

Especially necessary for future study is development of methods of reaching the alcoholics in ghetto areas and providing innovative services to minority groups with special need; for example, American Indians.

Recently a longitudinal study began of the durability of rehabilitation of alcoholics provided services by State vocational rehabilitation agencies. Also, an evaluation of eight expansion projects supported by transfer funds from the National Institute of Alcohol Abuse and Alcoholism was initiated. Currently, negotiations are underway between the Social and Rehabilitation Service and the National Institute of Alcohol Abuse and Alcoholism for the transfer of funds to the Social and Rehabilitation Service for the establishment of a number of projects associated with the rehabilitation of the alcoholic.

Special foreign currency program--It is also planned that the Special Foreign Currency Program will be coordinated with the domestic program and the National Institute of Alcoholism Abuse and Alcoholism. Projects that have already been completed or nearing completion in Poland and Yugoslavia are pointing the way to progressive action in other countries concerned with the problems of increasing numbers of alcoholics and problem drinkers.

Programmers in the field recognize that the alcoholic and problem drinker need more comprehensive services including psychological, social and vocational rehabilitation. Other countries are increasingly concerned with these problems relating to causal relationships, prevention and early rehabilitation programs for the patient and his family. New projects emphasize an interdisciplinary approach to ascertain the most efficient methods of bringing about vocational rehabilitation in a community setting for alcoholics and problem drinkers.

DRUG ABUSE

(Obligations)
(In thousands)

	1971	1972	1973	1974 Estimate	1975 Estimate
Public Health Service					
Alcohol, Drug Abuse, and Mental Health Administration					
National Institute on Drug Abuse...........	$54,380	$116,675	$181,283	$272,414	$216,615
Office of Education					
Drug Abuse Education......	5,610	12,400	12,322	5,700	---
Elementary and Secondary Education...............	---	1,300	1,300	1,300	---
Higher Education..........	150	95	106	100	---
Subtotal, Office of Education........	5,760	13,795	13,728	7,100	---
Social and Rehabilitation Service					
Community Services Administration..........	1/	1/	58,165	64,000	73,600
Rehabilitation Service Administration:					
Basic State grants......	1,859	5,031	6,090	6,930	8,464
Innovation grants.......	46	---	---	---	---
Expansion grants........	145	342	629	554	---
New Career grants.......	136	135	125	---	---
Rehabilitation training.	20	395	92	---	---
Rehabilitation research and demonstrations....	151	652	790	800	800
Subtotal, Social and Rehabilitation Service..........	2,357	6,555	65,891	72,284	82,864
Total..........	62,497	137,025	260,902	351,798	299,479

1/ Obligations not identifiable

INTRODUCTION

Heroin abuse emerged in the middle 1960's as a problem of major significance. Domestically, estimates of the extent of heroin abuse at one point reached beyond 500,000 addicts and users. Available data revealed that an alarming six year trend of increasing heroin addiction has been halted over the past two years. Enrollment in treatment programs has greatly increased. Furthermore, the rates of overdose death and property crime - regarded as significant indicators of the incidence of heroin addiction - have declined through most areas of the country since the start of the heroin epidemic. These are hopeful signs that the epidemic has been stemmed. They do not provide an occasion for any slackening of effort. Heroin continues to be our number one drug priority.

With respect to the non-opiate drug category, the abuse of barbiturates, amphetamines, hallucinogens and cocaine are emerging as areas of concern for us. The extent of non-medical use of barbiturates and amphetamines is difficult to estimate. The barbiturates, sedative hypnotics, amphetamines and related stimulents problem is not confined to use of drugs obtained from illicit traffic. We believe that the social costs related to the abuse of these substances can be minimized through continuing availability of treatment, appropriate education efforts and informing the medical profession about the abuse potential when prescribing these substances.

The use of hallucinogens is a reasonably recent development in the United States. There is a general impression among some of those in touch with treatment and crisis centers that the popularity of hallucinogens is declining; however, data are not available to confirm or dispute this perception. The social costs of hallucinogen abuse relate primarily to the unpredictability of these effects. Adverse effects can range from overdose to the precipitation of narcotic or depressive episodes even of those who have used these substances previously without such effects.

While it is convenient for the purposes of discussion to consider each of the primary drugs of abuse separately, most involved drug abusers use at one time several different drugs not individually but in combination. Patterns of multiple drugs of abuse - also referred to as polydrug abuse - include either drug substitution or the use of several drugs simultaneously. These patterns of multiple drug use make it difficult to assess the size of the problem. While we may be able to estimate the number of abusers of each substance, the overall estimates are not necessarily conclusive since a single individual may be counted in more than one group. We can say, however, that in the last several years there appears to have been an increase in the number of multiple drug users. Given the widespread availability of many of the substances employed in multiple drug patterns - through both licit and illicit channels - there is a need to address and counter the spread of multiple drug abuse.

PUBLIC HEALTH SERVICE

Alcohol, Drug Abuse, and Mental Health Administration
National Institute on Drug Abuse

The policies that will guide the National Institute on Drug Abuse programs in treatment and rehabilitation are: 1) to make existing facilities available for the treatment of multiple drug abusers as well as the abusers of non-opiate substances; 2) to develop Federal outreach programs to seek out and bring to treatment hardcore heroin addicts and other abusers; 3) to upgrade the quality, accountability and management efficiency of Federally funded drug treatment programs; 4) to develop improved rehabilitation, job counseling and job placement services designed to return treatment patients to a productive life; 5) to improve the capability of the newly established Single State Agencies for Drug Abuse Prevention to plan and deliver drug abuse prevention services at the local level in accordance with the precepts of the New Federalism; 6) to maintain a static treatment capacity of 95,000 federally funded treatment slots.

In the area of training there are basically three objectives to be accomplished by the Institute. The first, to provide a sufficient number of qualified personnel to staff treatment and prevention programs, as well as State level program planning, coordination and implementation. The second is to train members of the medical and social service professions in drug treatment and rehabilitation techniques. And finally, to train the staff personnel of privately funded programs aimed at serving hard to reach high risk populations. The primary vehicles in the obtaining of these objectives are the six training centers currently in operation to train the staff of growing numbers of NIDA, VA and DOD drug and rehabilitation programs as well as locally funded centers. The training program includes such topics as pharmacology, specialized hospital care problems, alternative approaches to polydrug and opiate abuse, individual and group techniques and program management. Specialized curricula pertaining to Single State Agency functions also include techniques for problem identification, program planning and fiscal management.

The National Training Center administered by NIDA will continue to serve as a medium for developing, validating and testing those training techniques which have potential for application for drug abuse rehabilitation and prevention programs. This center also trains Federal, State and local government officials and hospital professionals engaged in community drug prevention programs.

The five major priorities in research to be carried out by NIDA in compliance with the 1974 Federal strategy for drug abuse and drug traffic prevention are: 1) developing new pharmacological therapies, including narcotic antagonists and long acting narcotic drugs and integrating them into an optional treatment program; 2) gauging the abuse potential of new drugs and tracking new patterns of abuse; 3) continuing research into the long term effects of marihuana use; 4) further advancing current epidemiological knowledge of drug abuse; 5) elucidating sociocultural, family and personality variables relating to potential drugs of abuse.

Work also continues in the area of basic research to contribute to enhance our understanding of the physiological correlates of drug abuse and particularly the biochemical mechanisms of action of the various drugs of abuse.

TREATMENT

The principal focus in treatment during FY 1974 has been the National Institute on Drug Abuse's effort to consolidate the rapid expansion of the past three years by keeping the funding of new treatment programs to a minimum while enriching the quality of services provided by continuing programs, and emphasizing evaluation and demonstration projects to increase the effectiveness of existing programs. Since 1971 there has been an increase of almost sevenfold in community-based treatment capacity. In 1971 there were 23 projects with a treatment capacity of 13,177 patients per year. By December 1973 there were 312 programs with a total capacity for treating 94,000 patients. Included in these latter figures are 69 drug abuse treatment projects transferred from the Office of Economic Opportunity in August 1973. These programs are being reoriented, where necessary, to conform to Institute standards and guidelines and, where possible, merged into existing Institute programs. This entire effort represents a major contribution toward enabling citizens in every region of the country with drug abuse problems to find help.

Treatment programs fall into four major categories. The first, assisting communities to establish treatment programs for narcotic addicts and drug abusers through the awarding of grants, is funded under the provisions of the Community Mental Health Centers Act and the Drug Abuse Office and Treatment Act of 1972. Programs in the second and third categories utilize the contract mechanism available under the DAOT Act to pursue the same principal objective. One program involves state-wide contracts under which individual projects are subcontracted by the state; the other allows for contracting with specific existing agencies whose patient load cannot be managed with available resources. The fourth category is a civil commitment program conducted under Titles I and III of the Narcotic Addict Rehabilitation Act (NARA) and is totally funded and operated by the Federal Government. These categories are described in detail below.

The Community Assistance Grant Program

Title IV Grants

The Community-based treatment grants authorized by Title IV of Public Law 89-793 enabled us to establish the first six community treatment centers as demonstration projects in FY 1968. Four of these grants have been converted to drug abuse service project grants; one has been taken over by the state agency; the sixth will be funded through FY 1974. By the end of FY 1974 this category of grant will be phased out.

Staffing Grants (Sec. 251, CMHC Act)

Staffing grants provide funds to pay a portion of the salaries of treatment personnel in drug abuse treatment centers. Only 24 of these staffing grants are now in existence since the drug abuse service project grants are more desirable from the recipient's viewpoint. No additional grants were awarded in FY 1973 under this authority and no new awards are planned for FY 1974 or FY 1975. The funding level of these programs is currently $16,500,000 providing treatment capacity for 12,700 patients.

Drug Abuse Service Project Grants (Sec. 256, CMHC Act)(Sec. 410, DAOT Act)

Drug abuse service project grants are awarded on a matching fund basis for the total operational costs of projects for the treatment of narcotic addicts and other drug abusers. To obtain an award a program must offer one or more of the following services: detoxification, institutional, or community-based aftercare. Since the funding of the initial 16 projects at the end of FY 1972, this program has expanded to its current total of 16 projects and, with the gradual merging of transferred OEO grants into the program, will total about 195 projects by the end of FY 1974. Including the OEO transfer grants, the current funding level of this program is $90,300,000 and provides a treatment capacity for 53,400 patients. As indicated by its rapid growth, this program has been the mainstay of the community assistance grant effort. In FY 1974 the emphasis of this program is switching from the rapid funding of new projects to increasing the quality of services in established projects, and few, if any, new projects will be funded. National interest in these programs remains high, as evidenced by the receipt of 33 applicants for new drug abuse service projects during the current review cycle; 29 approved-but-unfunded grant applications are on hand from the previous review cycle.

Initiation and Development (I&D Grants)(Sec. 261, CMHC Act)

I&D grants are awarded to assess local needs for programs of services for narcotic addicts and drug abusers; to design such programs and obtain local financial and professional assistance to support them; and to foster community involvement in program development. Each grant may cover up to 100% of the total costs but is limited to $50,000. It is a one-time award for a maximum of one year. There are currently 19 of these projects funded and no additional funds are earmarked for this program in FY 1974. This primarily is a result of the effect that formula grant money to states is having on the planning stages of the grant process.

Formula Grants (Sec. 409, DAOT Act)

Formula Grant Awards, made under the authority of Section 409 of the DAOT Act, provide financial assistance to states for planning, establishing, conducting, and coordinating projects for the developmnt of more effective drug abuse prevention functions in the state and for evaluating the conduct of such functions. Funds are allocated to states based on a tripartite formula developed jointly by the DHEW and the Special Action Office for Drug Abuse Prevention. The three factors are: (1) financial need as determined by the relative per capita personal income for each state; (2) drug abuse resource need as measured by the relative per capita amount of local federal drug abuse dollars within each state; and (3) program need as measured by an estimate of chronic drug abusers in each state relative to the total national population of chronic abusers.

The primary focus of this program in 1973 was on the development of effective state plans in each state. The goal for 1974 is to have each state and territory operating under an approved state plan. It is anticipated that a substantial portion of the funds will be used by the states to provide drug abuse services. The allowance for FY 1974 is $25,000,000.

In FY 1975, formula grants will serve as the mechanism through which the state begins to assume coordinating responsibility for drug abuse programs including those which had previously been funded through individual categorical awards. They will be awarded to the states to cover multiple aspects of drug abuse, e.g., planning, treatment services, information development and reporting, and program administration. The funding of drug abuse activities in this manner will provide a base suitable for incorporation into whatever ultimate system of funding is adopted for state drug abuse activities, including special revenue sharing, National Health Insurance or other forms of third party payment.

Demonstration Treatment Grants (Sec. 252. CMHC Act)(Sec. 223, DAOT Act)

The purpose of these grants is to support and evaluate treatment projects which demonstrate effective methods of delivery services; to permit advance intelligence on new modes and means of drug abuse and addiction treatment; and to provide appropriate services to meet the new and existing problems related to substance abuse. These projects are for a maximum of three years and may be supported by up to 100% in Federal funds. The first three of these projects were awarded in FY 1972 and currently there are 11 projects at a funding level of $6,800,000. It is anticipated that in FY 1974 an additional 15 new projects will be funded for $6,000,000.

Specifically, in FY 1973 continuing attention was placed on innovative ways of re-introducing heroin abusers already under treatment into the mainstream of our economy through work support programs, thus eliminating the need for welfare and other correlates of unemployment. Also emphasized were new methods of delivering services such as the delivery of services by labor unions and the treatment of alcoholics and drug abusers in the same facility. Several other large projects called for monitoring the loug-term effects of methadone treatment upon body functions and upon performance. In FY 1974 we are continuing to develop these projects as well as to initiate new efforts which concentrate on special groups such as teenage addicts, the female addict, addicts with severe psychiatric disorders, and addicts of minority populations in order to uncover better ways of adapting programs to the needs of these groups.

TASC Grants (Sec. 223, DAOT Act)

The Treatment Alternatives to Street Crime (TASC) grant program, initiated in FY 1973, involves identifying the heroin dependent person shortly after arrest and offering opportunities to enter a variety of treatment programs. The overall goals of TASC are to decrease the incidence of drug-related crimes with its attendent cost to the community, to interrupt the drug-driven crime cycle by offering treatment for drug addicted arrestees, and to decrease the problems in detention facilities resulting from arrestees who are committed as addicts. Eight new projects were funded at the end of FY 1973 under this program at a Federal level of support of $5,400,000. Since these programs have evolved as primarily referral services out of the courts, it is planned in FY 1974 that the major portion of their funding be taken over by the Department of Justice with the Institute continuing to fund only the relatively small portion of direct treatment in each project. It is projected that this will amount to about $1,340,000 in both FY 1974 and FY 1975 and will provide treatment capacity for 800 patients.

Polydrug Grants (Sec. 223, DAOT Act)

The initiation of this program in the latter part of FY 1973 is representative of the Institute's effort to adapt our programs to the changing drug scene. The increasing problem of the abuse of stimulants, hallucinogens, inhalents, and other substances or preparations-alone, concurrently, or in combination with other substances independent of concomitant narcotic or alcohol abuse-is the target area of the polydrug grants. These grants are designed as demonstration projects to initiate a systematic approach to the problem, penetrate the most severe aspects and areas of polydrug abuse, determine the potential consequences of abuse, and begin developing a cadre of specialists in the treatment of non-narcotic drug abusers. Limited direct treatment is provided through the arrangement with the inpatient facilities of designated hospitals. Eight projects were funded by the Institute under this program in FY 1973 for a total of $2,800,000 in federal monies. We anticipate that by the end of FY 1974 the Institute will be supporting 20 projects at a total federal support level of $6,000,000.

The State-wide Services Contract Program
(Sec. 410, DAOT Act)

This program is a cost-reimbursement, cost sharing contractual mechanism through which the Institute can fund a number of drug treatment protects under the "umbrella" of the Single State Drug Authority. The state assumes responsibility as prime contractor for the various subcontract agencies with a federal funding period of one year and possible refunding for up to three years. This program began in FY 1973 with contracts being let to the states of New York, New Jersey and Texas. The total federal support of these three contracts is $16,405,000, providing treatment capacity for 10,131 patients in a combined total of 32 operational subcontractors. It is anticipated that these programs will be continued at approximately the same level in FY 1974 but that the effect of state formula grants and revenue sharing will result in a diminution in federal support by FY 1975.

The Rapid Expansion (Waiting List) Contract Program
(Sec. 410, DAOT)

This program provides for the rapid expansion of treatment facilities to treat drug abusers on a fee-for-service contract basis. These contracts are primarily aimed at relieving the burden placed on existing agencies who need funds to treat patients requesting care, but for whom the agency is unable to do so because they do not have the funds to expand their capacity. In a few justified cases, this contractual mechanism can be used to fund new treatment facilities to meet existing needs in communities where there is not an established drug abuse treatment center. The contracts are always made with or through the individual state drug abuse authorities. At the end of FY 1973, the initial year of this program, there were ten projects funded for a total amount of $7,850,000 providing a treatment capacity for 4,703 patients. With the absorption of the OEO rapid expansion contracts in August of 1973, the level of this program more than doubled. Since these programs are not by nature long term projects but are designed more as emergency efforts, it is the continuing objective to merge these projects with the treatment grants, statewide contracts, or other appropriate agencies for long term support. It is anticipated that 15-20 of these contracts will still be supported via this mechanism at the end of FY 1974 for a total cost of about $10,000,000, providing a treatment capacity for 6,600 patients. In consideration of the nature of this program, it is expected that FY 1974 funds will be sufficient to meet existing needs and, therefore, no additional funds have been budgeted for this program in FY 1975.

The NARA Contract Program (NARA Act)

Approximately 11,000 patients have received treatment under this civil commitment program since its inception in 1966. In the past, the inpatient phase of the program was conducted at the Clinical Research Center in Lexington, Kentucky, or the Center at Fort Worth, Texas. Now that these facilities have been or are in the process of being transferred to the Justice Department (the CRC in February 1974) all future services will be performed contractually at community facilities. There are currently 22 community-based agencies providing evaluation and examination, inpatient care, and supervised aftercare under contracts administered by the Institute. The present patient population in the civil commitment program is 1,027 persons. Efforts are currently being directed toward the integration of NARA agencies with community-based projects at the community mental health centers and with independent drug abuse service projects. New civil commitments are diminishing each year, and it is expected that program support will decrease during FY 1975.

Project Monitoring

One of the continuing problems resulting from the rapid expansion of NIDA supported treatment facilities has been our inability to maintain a monitoring schedule to assure adequate provision of treatment services. In recognition of the very limited availability of new funds during FY 1974 and 1975, we are working to solve this problem by virtually eliminating all efforts to develop new projects, and concentrating on the monitoring of on-going programs.

An evaluation project, based on a data collection system which is an integral part of the Community Assistance Program, is currently under way. This assessment program follows the individual patient during treatment at the grantee agency from his admission to his discharge. The data collection system used employs a bi-monthly status evaluation form which provides information on treatment progress and patient response with respect to employment, drug and alcohol abuse, criminality, and other factors which influence behavior. The information thus acquired is maintained in a periodically updated computer file to be used as a source of data on patient loads, kinds of treatment delivered, and treatment outcome. Part of the project is to develop typologies of patients, relate these to the treatment approaches utilized, and assess how similar grouping of patients in various treatment modalities, and various groupings of patients in the same modality, behave in terms of indices of social functioning. Such analyses should lead to the possibility of better patient placement into appropriate treatment modalities.

Another project under development in this area consists of developing a working methodology for combining current knowledge and assumptions about existing patient, fiscal, and treatment circumstances in order to project the possible future effects and implications of alternative program decisions. Such a capability should provide considerable assistance in problem solving in the area of treatment and rehabilitation.

Future Projects Include Plans for:

(1) Emphasizing the re-entry of treated drug abusers into the mainstream of society both by developing special demonstration projects in the employment of addicts and enriching the quality of vocational rehabilitation services in existing projects. This effort will take into account the

varying backgrounds of the drug addict, the resources available in treatment centers, and the needs of the current job market.

(2) Special efforts to engage those drug abusers in treatment who do not take advantage of services already available. This will involve active outreach into the courts, schools, and other appropriate community foci to lend increased identity to our programs.

(3) Increasing the expertise of Institute project staff members to enable them to more effectively deal with project clientele. This task will involve encouraging in-house project training as well as ensuring that all projects make effective use of the staff training programs available through the Institute's six Training Centers.

(4) Re-evaluating the cost factors of the various treatment components within our projects to allow for the enriched services indicated above. Relatively low cost factors had been originally established for our projects in line with our initial task to establish adequate treatment capability for all addicts desiring it. Now that this has been essentially accomplished, and services provided are being broadened, increased cost factors must be considered.

RESEARCH

The National Institute on Drug Abuse supports a wide spectrum of extramural research projects on problems associated with drug abuse - from investigating psychosocial and epidemiological factors influencing drug abuse to studying the basic chemistry of abused substances. In addition to sponsoring research through grants to non-profit research organizitions, contracts are awarded to both for-profit and non-profit organizations to perform research tasks which focus on certain critical problems of drug abuse.

Major areas of research are outlined below.

Narcotic Addiction and Its Treatment

Many aspects of narcotic addiction still hold questions for research. Basic research on the mechanisms of opiate action has made significant progress toward identifying an opiate receptor in the brain. While the full significance of this finding is not yet clear, it certainly offers possibilities for the development of more effective, longer-acting narcotic antagonists relatively free of side effects. Such substances, which block the action of opiates without being in themselves addictive, may ultimately prove to be highly effective treatment and preventative tools. Preliminary results in our early clinical trials are encouraging. Current NIDA efforts in this area range from the development of promising new compounds to the clinical testing of materials already demonstrating therapeutic potential. Intensive work is underway to develop a range of dosage forms and therapeutic vehicles which will extend the action of these drugs and make day-to-day therapeutic motivation of the addict less important. If such drugs can be developed for widespread use, they may also prove of value in the prophylactic treatment of populations with high risk of becoming addicted. Despite the promise of newer chemotherapeutic approaches to addiction, much remains to be learned about existing treatment approaches. Despite certain limitations, methadone maintenance has been an important factor in improving the functioning of many patients in society. The physiological, psychological, and sociological implications of this form of treatment continue to be studied. In addition, the development of a long-acting form of methadone is being supported through several grant and contract efforts and other possible pharmacotherapeutics are being evaluated.

Much remains to be learned about the developmental and psychosocial factors which influence recurrence of drug dependence. Substantial changes in community attitudes toward heroin use have been reported, and may relate to decrease in such use. Additional significant factors may be physiological and genetic as well as psychosocial. For example, little is known about the effects of narcotic addiction and methadone maintenance on women and offspring. Along with these and other genetic factors, the relationship of opiate abuse to various aspects of neural chemistry is being explored. Advances in basic research, although unpredictable, could easily alter our entire approach to the prevention and treatment of addictive and other drug dependency disorders.

New Therapeutic Approaches to Drug Dependence

Although chemotherapeutic approaches to the problems of drug dependence have received a good deal of attention in our research program, the psychological aspects are equally important. Despite the efficacy of chemotherapy, it is important to provide a range of psychosocial treatment and services so that addicts and others who are dependent on drugs may find other sources of satisfaction. Increased attention is being directed to those aspects of the individual's psychological environment which "reward" him ambivalently for continuing his drug dependence or for seeking and profiting from treatment. By carefully examining the psychological factors in the patient's social and institutional environment, we should be able to manipulate them in order to increase the probability of therapeutic success. Research in behavior modification techniques which are carefully designed to channel the individual's behavior into a socially desirable direction includes the systematic examination of the addict's behavior as affected by heroin use and the influence of various treatment techniques in modifying this behavior. It also includes the systematic manipulation of rewards and punishments by therapist-patient consensus to reach agreed upon therapeutic objectives.

Marihuana Research

Because of the extensive growth in use of marihuana in our society, especially among the young, a major marihuana research program has been underway for several years. Detailed summaries of the findings of this program may be found in the First, Second and Third Annual Report to Congress on Marihuana and Health.

A number of major questions continue, however, to be unanswered or only partially answered and require further investigation. These include the following:

1. Reputable investigators have recently reported conflicting results with regard to possible relationships between marihuana use, chromosomal damage and birth anomalies. Some studies report no increased chromosomal damage, others a significant increase and others mixed patterns. These differing reports require further study and clarification.

2. Completed and ongoing studies on the immediate effects of marihuana use at typical social dosage levels demonstrate various types of temporary mental impairment during periods of intoxication. Generally, there is evidence that short term memory is impaired and that impairment of other modes of intellectual and psychomotor functioning increases as task complexity increases. Recently, evidence has shown that marihuana intoxication produces impairment in driving function which in turn may contribute to motor vehicle accidents.

3. The question of long-range effects of chronic use requires further clarification. Some studies of chronic users here and abroad seem to show little impairment after many years of use. However, there are important methodological problems in conducting these studies, such as insuring that substantially impaired subjects would be equally likely to be enrolled in the study as successfully functioning users. These problems, and the types of impairment described in less systematic case studies, make more extensive long term user studies imperative. Eventually, we hope to be able to analyze long-term effects of marihuana smoking in the same way that long term effects of tobacco smoking are now reported, i.e., not be limited to reporting that the majority of long term smokers do not suffer serious consequences, but instead be able to show what increase in serious consequences occur, if any, in long term users, albeit in a minority of them.

4. The synthesis and the increased availability of limited quantities of marihuana metabolites are making it possible to undertake careful study of the transformation marihuana undergoes in the body and its mode of action. Such research provides new clues to more subtle toxic effects that might otherwise be missed and to adverse effects that may result when marihuana is used with other drugs. Studies of the interactive effects of marihuana used in conjunction with other drugs, e.g., alcohol, barbiturates, stimulants, over-the-counter and prescriptive drugs, etc., are being undertaken. Some evidence from animal studies indicates that marihuana use modifies the effects of other drugs in ways that may be significant for human use, and a source of danger.

Other Drugs of Abuse

Marihuana and narcotic research has until now been the most common or serious problem area of drug abuse study. However, research into other drug abuse areas must now be conducted. Amphetamine abuse, for example, continues to be an important area of research; this includes the development of antagonists analogous to narcotic antagonists which block the psychomotor action of the amphetamines. Cocaine is becoming more widely abused and we are currently encouraging research into its physiological effects. Barbiturate abuse remains a significant problem and work in that area continues. The typically heavy drug user is abusing not only one but many different drugs, often simultaneously. Much effort is being expended in understanding the patterns of polydrug use, factors influencing progression to other drugs, and the long-term implications of such use. As new agents of abuse come into wide use, their use in conjunction with the many other drugs available in our society will also be studied. Drug abuse is a form of behavior disorder with clear relationships to other types of compulsive and addictive disorders, and to a wide variety of social and biological issues. These roots and relationship to wider processes must be explored as well.

TRAINING AND EDUCATION

The increased growth of all types of drug programs resulting from Public Law 92-255, the Drug Abuse Office and Treatment Act of 1972, and the formation of NIDA has resulted in a sharp increase in need for job specific training throughout the entire drug abuse field. The Institute supports four specific program areas to meet training needs in on-going projects and new activities in the drug abuse/rehabilitation and prevention field. These include 1) training programs funded through both grants and contracts. These programs range from short-term skill training such as crisis center counseling skills, provided primarily through contract funded training centers, to long-term professional degree programs provided through training grants to colleges and universities; 2) education/prevention grant programs stressing community, youth and minority involvement; 3) grants supporting career teachers on medical school faculties to assure development of an addictive disorders curriculum in medical schools. Two training centers have been established to support this program; 4) manpower studies and program evaluations established through contracts to assist in identifying both short and long-term manpower needs by skills as well as numbers. An evaluation of all program thrusts is being carried out in order to improve manpower/training activity effectiveness.

Progress and Accomplishments

During FY 1974, all manpower activities have been consolidated through the implementation of a National Training System concept. The NTS, an evolving system in its initial stages, has established:

1. Mechanisms for identifying training resources within the drug abuse treatment/rehabilitation and prevention field -- those funded by NIDA as well as those available through other funding sources (i.e. Office of Education Programs, Drug Abuse Council activities, and others)

2. Communication mechanisms for sharing of information and resources throughout all elements of the NTS. This includes a common calendar of training courses, sharing of faculty and bibliographies, and sharing of curriculum designs.

3. Research into existing and projected manpower needs and application of this research into specific training programs. The two major efforts in this area include a major manpower assessment which will be complete in FY 1975 and the research and development activities of the National Drug Abuse Training Center.

4. Integration of a career mobility policy into all training efforts through incorporation of the policy into contract work scopes for all regional training centers and establishment of a job bank program by grantee.

As the NTS concept develops, additional activities are being initiated to insure greater utilization of all resources and a more effective approach to manpower needs as they develop. This will eliminate much of the "crisis" type of operation characteristic of many drug abuse activities in the past.

Specific elements of the NTS supported by the four program areas mentioned earlier include:

disorders curriculum for his medical school. Projected funding for FY 1974 will support thirty (30) new career teacher grants. This program is being sponsored jointly by the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism. The career teachers are currently located at the following schools of medicine: Washington University, Boston University, Albany Medical School, University of Minnesota, Medical University of South Carolina, University of Texas, University Hospital, Charlottesville, Virginia, Emory University, University of Pennsylvania, Bronx Municipal Hospital Center, University of Pittsburgh, University of California-Irvine, University of New Mexico, and Georgetown University.

4. Evaluation:

A contract for major manpower assessment will provide the first definitive information on manpower levels in drug abuse treatment programs, as well as existing and projected training needs, in terms of specific job skills. The final report of this contract will be available in FY 1975. Additional contracts evaluating all aspects of manpower resource funding activities are being let and it is anticipated they should be completed by the end of FY 1974.

Objectives for 1975:

1. Further development and implementation of the NTS, with greater stress on incorporating elements into the communications and material exchange from funding sources other than the Drug Abuse Training Branch.

2. Incorporation into the NTS of data resulting from the manpower study, other research and development efforts, and evaluation programs.

3. Expansion of the career mobility concept into all major training elements of the NTS.

4. Initiation and support of credentialling efforts and other program elements that will support an effective career mobility concept in the drug abuse and human services field.

5. Increased emphasis in both training and education programs on the need of youth and minorities, especially the Spanish-speaking area.

6. Substantive support in program development and training of trainers for single state agencies and other new training starts in the field.

7. Increased focus on paraprofessional training with a concomitant decrease in professional/graduate/undergraduate level training, especially in the area of social work.

8. Specific assessment of programs that have been in operation for two years or more with a view toward phasing out unsuccessful programs.

1. Training Programs

Within this area there are (a) sixty-nine (69) active grants with approximately 20 new starts projected for all of FY 1974 and (b) seven (7) contracted training centers, -- the National Drug Abuse Training Center (Washington, D.C.) and six regional training centers (Chicago,Ill.; Miami, Fla.; New Haven, Conn.; Oklahoma City, Okla.; Oakland, Calif.; Queens, N.Y.). The NDATC will have researched, produced and validated training designs in a number of critical areas including youth intervention, emergency room procedures, counseling, management, and training of trainers. The contract centers will, by the end of FY 1974, have trained over 6,000 workers at all levels in job specific areas including program management, administration, clinical skills, and counseling.

The training grant program also includes two major training centers - the National Institute on Drug Programs which provides an A.A. degree for ex-abusers working in drug programs, and a center at U.C.L.A. which provides skill training for workers in treatment/rehabilitation programs. Other grant training activities include: a training program for career ladder mobility for paraprofessionals in the medical and health related fields at the University of California-San Diego, La Jolla, California; a career training course for paraprofessionals in the treatment and rehabilitation field sponsored through Skill Advancement, Inc., in Harlem, New York City; a counselor training program located at Our Lady of the Lake College, San Antonio, Texas, for training Chicanos to meet the needs of the Mexican-American population; a paraprofessional training program for treatment/rehabilitation workers leading to an A.A. degree from Pima College in Tucson, Arizona; and an emergency room personnel training program administered by the Ohio Hospital Association, Columbus, Ohio.

2. Education/Prevention Programs

Within this area there is a total of 24 active grants with approximately 20 new starts projected for all of FY 1974. Emphasis in this area has been on youth and community programs, particularly where they impact on minority populations. Some of the grants in this area include: an education program in Glen Cove, New York, for grades K-7 which incorporates different education and counseling methodologies for early intervention; a peer group training approach to the drug abuse problem being taught through the Southern Illinois University at Carbondale, Illinois; an alternative environment provided for drug abusing youth and other disadvantaged youth who are high risk potential users in Gloucester, Massachusetts; provision of opportunity for the acquisition of employable skills; and a unique program combining peer counseling with senior citizen counselors who are over 55 years of age and who are trained to counsel potential drug users in Medford, Oregon.

3. Addictive Disorders Career Teachers

Current grants are located at 14 different medical schools where a career teacher is specializing in the field of addiction and drug abuse. The program includes: training period at two centers for career teachers at Baylor College of Medicine, Houston, Texas and State University of New York Downstate Medical Center. The career teacher will eventually develop an addictive

SCIENTIFIC AND PROGRAM INFORMATION

The Drug Abuse Information Programs Branch (DAIP) was established in June 1973 to collect and disseminate scientific, technical, and programmatic information on drug abuse. DAIP is responsible for the design and implementation on drug abuse information systems, for providing technical assistance concerning their installation, and for serving as a central source of information for the Institute.

The major objectives of DAIP are to collect and maintain program and management information emanating from federal and state drug abuse prevention efforts and to provide periodic and special reports and analyses for operational and planning purposes by all federal agencies. DAIP develops information systems for ADAMHA and other federal agencies and works with components of NIDA in the development of internal systems. DAIP provides consultation to and liaison with other federal, state and private agencies with information programs on drug abuse.

Several major projects are presently being conducted to support an integrated management system (IDAMIS). Among the files which comprise IDAMIS are:

PROMIS, which is a file of federally funded projects, containing data elements relevant to the financial provisions and work scope of individual federal grants and contracts for treatment, training, education, research, and other drug abuse prevention activities. This file provides information to state and federal managers in terms of the current allocation of financial resources and other information related to programs, such as capacity and scope, so that decisions can be made concerning new programs or continuation of existing ones.

The Client Oriented Data Acquisition Process (CODAP)-National Management embodies the single uniform reporting requirement for client-related data to support the decision-making needs of federal agencies with respect to performance, planning, and follow-up in the area of treatment and rehabilitation. With increasing emphasis on the involvement of single states in the management and planning of programs, CODAP is being adapted to meet those state needs. Thus, information from CODAP can be made available at all levels from communities to federal agencies.

Media Recall, provides an on-line computerized locator for drug abuse prevention related articles disseminated by the media and is keyed to a separate microfilm library of the original issuance. Forty-nine thousand documents have been added to Media Recall since FY 1973.

Drug Abuse Prevention Resource Units contain the locational, linkage and selected appropriate data elements for all Drug Abuse Prevention Resource Units, regardless of the sources of their financing.

REFERENCE contains, for all major communities, data elements relating to their demographic and socioeconomic characteristics, their employment situation, their general criminal justice system statistics and other factors describing them as geopolitical entities.

The basic objective of IDAMIS is to provide an information flow which makes it possible for top management to perform its assigned planning and control functions. It will further enable management to ensure that mission objectives are met within authorized funding and time limits. IDAMIS will accomplish a number of secondary objectives which are as follows:

1. The design of a system that integrates processing, correlation, retrieval and display of management information into a continuous operation which reduced manual manipulation of data to a minimum.

2. To provide top management with complete visibility (information in depth) for continuous review, at a moment's notice.

3. To facilitate updating of baseline information with a minimum of effort.

4. To provide a common language for all levels of management as a ready tool for use in executing their assigned responsibilities.

5. To facilitate the integration of schedule, cost and performance data for impact analysis and long range planning.

6. To provide a means for channeling decisions and actions through the proper level of management for execution and follow-up.

The Integrated Drug Abuse Reporting Process (IDARP) is a reporting process that Single State Agencies can use to support the general management of their drug abuse prevention activities. The IDARP consists of CODAP and Drug Abuse Prevention Resource Units (DAPRU).

One of the major functions of DAIP is the operation of the National Clearinghouse for Drug Abuse Information. The NCDAI, established in 1970, has responded to over 12 million inquiries and has distributed over 27 million publications since its inception. The Clearinghouse distributes posters, pamphlets, publications, and other materials for use by the general public, researchers, teachers, physicians, interested groups and individuals. To meet the demand for more advanced material that lies between what is routinely available and what is contained in scientific source material, NCDAI produces a Report Series and a Reference Series which encompass research services on specific subjects in drug abuse. One such report published last year dealt with amphetamines, another on treatment modalities, and others on similar subjects.

In addition to collecting and storing, the Clearinghouse is also responsible for disseminating this information. The NCDAI prepares numerous information materials, including fact sheets, directories, bibliographies, and other publication, which are distributed to the general and professional public as well as to Government agencies, both federal and non-federal. The Clearinghouse is geared to answer inquiries and provide services to the general public as well as to special groups such as educators or research scientists. Inquiries which cannot be answered directly by the Clearinghouse are referred to the appropriate Government or private resources.

Resources and Materials File

The NCDAI's Resources and Materials (RMF) computer file contains abstracts and descriptions of books, pamphlets, journal articles, posters, films and other materials on drug abuse. This file, accessible by on-line terminals, stores over 17,000 abstracted documents which provide responses for technical inquiries and form the basis for published bibliographies.

The NCDAI system uses this computer file to develop its Annotated Bibliography on Drug Dependence and Abuse. The publication is constructed in a similar fashion to the computer file itself and categorizes references according to the identical major subject areas. The bibliography is updated annually. The Annotated Bibliography should be especially helpful to students, law enforcement officials, teachers, or researchers. A preliminary edition, Drug Dependence and Abuse: A Selected Bibliography was published prior to the Annotated Bibliography and is still available upon request.

Drug Abuse Current Awareness System

The production of Drug Abuse Current Awareness System (DACAS) represents new articles which are abstracted and entered into the RMF. Over 105,900 issues of DACAS have been distributed to federal and state government personnel and professionals in the drug abuse field.

The Resources and Materials File and DACAS will continue to be refined and evaluated in terms of acquisition, storage, and retrieval. Cost/benefit analyses will be conducted, and special consideration will be given to changes in software which may make systems more efficient.

Drug Abuse Communications Network

DRACON is designed to serve as the mechanism through which states, individuals, and groups can have access to accurate and current information from satellite information organizations.

The Clearinghouse has evolved its Drug Abuse Information Communications Network System by cooperating with several states and federal agencies also involved in developing information storage and retrieval services. The result is a program of stimulating and encouraging existing and newly formed drug abuse information centers to participate in the Clearinghouse DRACON Network.

The basic premises of the DRACON operation are to provide decentralizing access to large scale data bases and prepared materials so that regional needs may be met as closely as possible to the source of the problem, and to maximize the appropriate use of both national and local resources, increase cooperation between drug abuse information resources, and develop improved and truly responsive communications.

Media Pretest and Review Program

In order to assure that all materials produced by the Clearinghouse will effectively achieve the purpose for which they are designed, the Clearinghouse evaluates these publications prior to issuance through its Media Pretest and Review Program. Increasing emphasis is placed on evaluation, both pretest and post test. The NCDAI is participating, along with other Federal agencies, in the development of guidelines for the production of new drug abuse publications. During FY 1973, over 40 fact sheets and bibliographies were evaluated.

By observing the frequency of requests for searches of the literature, the Clearinghouse is able to keep attuned to changing information needs, new areas of interest and concern to the public, as well as shifts in currents and trends in the drug abuse field throughout the country. Development of resource materials is thus tied directly to the demands of the public.

The National Clearinghouse for Drug Abuse Information is expanding its information services to effectively handle the growing volume of sophisticated inquiries and to help promote the development of local capabilities.

The NCDAI has established and maintained a 3-day limit between receipt and response to inquiries.

There is an increase in the quality of response to sophisticated, complex inquiries.

The impact of state plans on operation and the future of DRACON is being assessed.

Personnel are being trained from all existing and new DRACON centers.

NCDAI is continuously evaluating information files for usefulness and quality of materials provided to the general public.

NCDAI is developing standards for access by remote users.

There is a continuous updating and modification of existing information files to improve retrieval and usefulness of the material.

DAIP is expanding the acquisition, organization, dissemination and analysis of all routinized recurring information flows, as well as providing information on drug abuse prevention to other federal agencies, states, local units of governments, the general public, special interest groups, the Congress, etc. DAIP extensively negotiates the terms of all reporting arrangements with federal and other respondents and assures the reliability, credibility and quality of the information acquired. DAIP is also responsible for the in-depth analysis of the information received to provide management with intelligence on the cause and effect of phenomena measured by the informational content of the incoming material. In addition, there is a continuous reevaluation of the need for established information flows and recommending the discontinuance of those no longer appropriate as well as for suggesting new or altered flows in response to changing management needs.

DAIP is responsible for developing an integrated data directory for all systems and developing a Drug Abuse Research Tracking and Analysis System (DARTAPS) for NIDA.

Since its establishment, DAIP has developed the Drug Abuse Prevention Resource Unit file and is currently responding to requests for programmatic information; developed the REFERENCE file; maintained Client Oriented Data Acquisition Process; and produced the first issue of Quarterly Statistical Brochure, which provides analysis of data from IDAMIS. In addition, 11 states have IDARP contracts, and it is expected that by the end of FY 1974, 50 states will be actively participating in IDARP.

OFFICE OF EDUCATION

Drug Abuse Education

The Drug Abuse Education Act of 1970 (P.L. 91-527) was enacted December 7, 1970 and authorized drug abuse education projects in schools and communities throughout the country. The program was designed to alleviate the drug abuse crisis by developing community awareness of the real nature of the problem and then concentrating efforts aimed at attacking the cause of drug abuse rather than treating its symptoms. This act expired on June 30, 1973. In fiscal year 1974 under an extension of the Act the program is operating with an appropriation of $5.7 million.

It has become increasingly evident that virtually all communities have some sort of drug problem and that problems vary from community to community. Although most communities are aware of the problem and want to respond to it, the Federal Government could not support projects in every community. A realistic and productive Federal role has been to train leadership for communities, to respond to specific needs and to evaluate and disseminate information about successful programs and techniques. To make the program responsive to as many communities as possible, the Help Communities Help Themselves program was initiated. Small grants were awarded to communities to support the training of community teams of five to seven individuals at nine regional training and resource centers. With the training received, the teams returned to their communities with the skills to assess and mobilize local resources for responding to their drug problems.

In fiscal year 1973, the program supported community teams through minigrants for training and supported the eight regional training and resource centers. It continued support for projects in State and territorial education agencies, college-based demonstration projects in drug abuse prevention, and school/community-based demonstrations. The National Action Committee provided technical assistance and consultation to the National Program and State and local projects.

In fiscal year 1974, a program of grants of up to $10,000 to provide two weeks of training at five regional centers for teams of five to seven persons from school districts and communities at large are being instituted.

Public Law 89-10 ESEA Title III, Supplementary Educational Centers and Services, enables schools to provide programs presently unavailable to children, to raise the quality of educational services already offered, and to stimulate the development and evaluation of experimental elementary and secondary education programs to serve as models. Fifteen percent of program funds is mandated for projects serving handicapped children. Other funds are mandated for projects in guidance, counseling and testing.

Originally, the Commissioner made grants directly to local education agencies. Beginning in fiscal year 1971, 85 percent of Title III funds were administered by State educational agencies, with fifteen percent to be used at the Commissioner's discretion within the State.

The Title III State Plans program in fiscal year 1972 reported that over 83,000 students were in drug education classes. These students were in 14 single projects and 26 multiple type projects that studies the drug abuse problem. This same effort was expended in fiscal year 1973 and it is estimated that the fiscal year 1974 level will be the same.

In fiscal year 1975, Federal support for Title III will be included in a new consolidated education grant legislative program.

Title I of the Higher Education Act of 1965 (University Community Service) pioneered the use of Federal funds to direct higher education resources toward the drug abuse problem. In fiscal year 1973, seven (7) projects reached 5,606 participants. The level of activity is not expected to be appreciably different in 1974.

SOCIAL AND REHABILITATION SERVICE

Community Services Administration

Social services directed at prevention of, alleviation of problem due to, and rehabilitation from, drug abuse are included within the scope of social services authorized by Titles I, IV, VI, X, XI, XIV and XVI of the Social Security Act. Administration of this program is within the Community Services Administration. Such services are usually provided as a compliment to an ongoing program. In FY 1975, it is estimated that States will be expending $7,800,000 Federal dollars on recipients and potential recipients of Aid to Families with Dependent Children, an additional $73,600,000 on recipients or potential recipients of Aid to Aged, Blind and Disabled and/or Supplemental Security Income.

Rehabilitation Services Administration

With greatly increased national attention to the problem of drug abuse, State rehabilitation agencies have been expanding their efforts to assist drug abusers in becoming gainfully employed. Medical and other therapeutic services are vital parts of the majority of drug abuse treatment programs. However, unless drug abusers are provided those services which will allow them to prepare, enter, and remain in gainful employment, the long-term success of drug abuse treatment programs will be questionable.

State rehabilitation agencies are uniquely qualified to assist the drug abuser in becoming a self-sustaining member of the community through appropriate preparation and placement in remunerative employment. Unlike many recently formed and relatively unproven service-providing organizations, vocational rehabilitation agencies have a successful history of assisting disabled persons handicapped by severe psychosocial problems. Experience gained in alcoholism and mental illness is now being carried over to drug abuse. Vocational evaluation, work adjustment services, specialized job training, placement assistance, and follow-up are vocational rehabilitation services which are characteristically needed by drug abusers.

State agencies serve drug abusers through special projects, as well as in the general caseload. Expansion grants are active in Georgia and Kentucky.

It is estimated that 4,700 drug abusers will be rehabilitated by State vocational rehabilitation agencies in FY 75, an increase of 600 from FY 74.

Number of Drug Abuse Rehabilitants

Fiscal Year Ending June 30	Persons Rehabilitated	
	Total	Drug Abusers
1971	291,272	1,254
1972	326,138	2,220
1973	360,726	3,600
1974	375,000	4,100
1975	394,000	4,700

Rehabilitation Services Administration

Rehabilitation research and demonstrations--Rehabilitation of drug dependent people requires the development of innovative, imaginative and aggressive techniques. Previous research has demonstrated the value of transitional living arrangements as rehabilitative adjuncts. The importance of considering and responding to the abuser's total environment during the rehabilitation process has also been shown. Therefore, therapeutic measures which include work training must be developed in partnership with private industry. Community adjustment services must be delivered in cooperation with local community resources. Moreover, although adequate follow-up services have proven to be a crucial component in the rehabilitation process, other elements must be as systematically investigated.

We do not yet know the most efficacious and cost-effective approaches to the organization and delivery of services. All of the following approaches have shown some promise for improving the rehabilitation of drug dependent people: (1) the availability of local, community-based services; (2) an integrated array of rehabilitation and social services; (3) immediate therapeutic intervention at crisis points; (4) the utilization of peer group dynamics, "confrontation" techniques, and ex-addict paraprofessionals; and (5) client advocates employing a variety of outreach methods. However, all of these require careful study of their effect upon the rehabilitation process.

An ongoing project in New York State is investigating new techniques and methodologies for the rehabilitation of hospitalized psychiatric drug abusers which involves a coordinated effort with non-psychiatric agencies involved in job development and job placement activities.

A project will soon be initiated which will involve a consortium of drug abuse treatment facilities so that their programs can be combined to provide comprehensive rehabilitation approaches including job development and job placement activities. On-the-job-training, with salary levels competitive with the open market, is one technique which will be employed.

The Special Foreign Currency Program is also administered by this Office. Currently, three projects are in various planning and developmental stages. One, in Yugoslavia, is designed to investigate the relationship between drug abuse and youth; a second, in Egypt, is planned to study the effects of sheltered workshops in the drug abuse rehabilitation process, and the third, in Pakistan, hopes to investigate drug use in the society as it relates to socio-cultural behavior.

MULTIPLE SCLEROSIS

Multiple sclerosis is one of the most common chronic diseases affecting the human brain and spinal cord. It is characterized by a loss of the fatty sheaths or myelin that surround the nerve fiber and derives its name from the plaques or patches of scarred (sclerosed) nervous fibers that dot the central nervous system (CNS). It is estimated that between 100,000 and 250,000 Americans suffer from multiple sclerosis and perhaps an additional 250,000 may be affected by other demyelinating disorders.

The Department's research activities into the causes and better methods of prevention and treatment of multiple sclerosis are centered in the National Institute of Neurological Diseases and Stroke of the National Institutes of Health, and in the Rehabilitation Services Administration of the Social and Rehabilitation Service for the rehabilitation of multiple sclerotics.

Obligations for programs in multiple sclerosis and related disorders

	1971	1972	1973	1974 estimate	1975 estimate
National Institutes of Health:					
National Institute of Neurological Diseases and Stroke..	$3,257,000	$3,611,000	$4,212,000	$4,589,000	$4,295,000
Social and Rehabilitation Services Administration:					
Basic State Grants...	1,000,000	1,113,000	1,213,000	1,260,000	2,010,000
Total................	4,257,000	4,720,000	5,430,000	5,349,000	6,305,000

NATIONAL INSTITUTES OF HEALTH

National Institute of Neurological Diseases and Stroke

Multiple sclerosis proceeds in a series of unpredictable attacks in most patients. In earlier stages, attacks are more often followed by periods of improvement known as remissions. With successive episodes, resulting scars in the central nervous system (CNS) become more numerous, more dense, and more destructive, causing progressively severe disability. It should be noted, however, that multiple sclerosis symptoms are not always progressive. Some patients experience one or two episodes and are never bothered again. Autopsies sometimes show evidence of multiple sclerosis on bodies of persons who were never aware of an attack when alive.

The onset of symptoms is rare before age 15 or after 55. The disease most commonly strikes between 20 and 40 years of age, with the peak of onset at age 30; it affects women more often than men.

The cause of multiple sclerosis remains unknown despite the compiling of enormous amounts of information from basic research, clinical studies, and epidemiologic investigations.

There is no treatment for multiple sclerosis that provides any significant, lasting benefit. From time to time new treatments have been reported helpful, but when tested have not proven effective. An example is ACTH (adrenocorticotrophic hormone). The final report of a five-year collaborative study supported by the National Institute of Neurological Diseases and Stroke (NINDS) on ACTH indicates that this agent is slightly beneficial during the first few weeks of treatment, but there is no evidence that the drug is effective for long-term use. The spontaneous episodes of exacerbation (increase in symptoms) and remission seen in multiple sclerosis make an evaluation of a particular therapy very difficult.

It is now believed that many patients may live up to seventy-five percent or more of their normal lifespan. Early death is usually the result of complicating infections of the lungs or bladder.

Multiple sclerosis exacts a very heavy annual toll of disability, striking its victims mainly in the most productive period of their early adult lives. The estimated cost of patient care in the United States alone is at least $250 million each year. Additional millions are lost to patients and to society as a consequence of jobs lost or the inability of those stricken to function as housewife and mother. The total economic loss is incalculable.

The National Multiple Sclerosis Society is funding a study of the socioeconomic impact of multiple sclerosis as related to patients in the Rochester area of New York. This study, which is being performed by an independent agency, should provide the first objective assessment of the socioeconomic impact of multiple sclerosis and may be useful in determining more precisely the impact on the entire Nation.

Basic Research Studies

Because multiple sclerosis is a disorder of unknown etiology (cause), much of the research remains at the basic level, at which the fundamental mechanisms of the disease can be elucidated. In fiscal year 1973 the NINDS funded a total of 69 research projects at a cost of more than $4 million. Many of the projects were in biochemistry and neurochemistry, others in immunology, neurophysiology, pathology, virology, and clinical studies.

A number of investigative routes are being pursued in order to find answers that will lead to the conquest of multiple sclerosis. Work is being conducted on the chemistry of brain lipids (fats) and immunologic responses in demyelinating disease. Chemical and metabolic characteristics of normal and abnormal myelin are being widely investigated in an attempt to learn more about how myelin is formed, maintained and degraded. A number of studies are centering on lymphocytes (cells involved in immunity) and lymphocytotoxic factors in the blood of multiple sclerosis patients. So far researchers have been unable to develop a true animal model for multiple sclerosis. For years however, scientists have been studying experimental allergic encephalomyelitis (EAE), an animal disorder that resembles multiple sclerosis, in order to use it as an analog. They have been able to induce EAE in a number of laboratory animals (guinea pigs, rats, monkeys, hamsters and rabbits) by injecting them with an extracted protein component of myelin. Studies into the mechanism of the EAE process and an understanding of the nature of the disease-provoking protein may hasten the conquest of multiple sclerosis.

In addition to basic research, a large patient study of immunological, virological, and neurochemical aspects relevant to demyelinating disease is now being conducted at the new Reed Neurological Research Center at the University of California at Los Angeles.

Recently, the NINDS joined the National Multiple Sclerosis Society in providing a grant to the Wistar Institute and the University of Pennsylvania School of Medicine for nearly $2.5 million over the next three years to support the most intensive collaborative study of multiple sclerosis ever made. The project is specifically designed to determine the etiology and pathogenesis (course) of multiple sclerosis, with emphasis on the virologic and immunologic apsects.

Another project is based on intrauterine inoculation of unborn monkeys with tissues from human patients with chronic diseases and infections. In many diseases, the fetus and young are more susceptible than the adult. This study was designed to exploit this greater susceptibility by inoculating the fetuses at 100 days of gestation. Animals are later delivered by cesarean section and the young held in isolation chambers for three to five years. Sera and spinal fluid are collected for study every three months. Some of the animals have undergone suppression of their immune mechanisms with the drug cyclophosphamide when they are one-year of age in an attempt to activate any latent infection.

The National Advisory Commission on Multiple Sclerosis

On October 25, 1972, Congress enacted Public Law 92-563, establishing the National Advisory Commission on Multiple Sclerosis to determine the most effective means of finding the cause of and cures and treatments for multiple sclerosis.

The bill required the Secretary of Health, Education, and Welfare to appoint nine members of the Commission, four from the NINDS Advisory Council and five from the public. This was done and the Commission has concluded a comprehensive review of the status of multiple sclerosis research, highlighting areas of promise. Working with the scientific community, it established a list of priorities for research looking to effective preventives or treatments. The Commission submitted its final report and recommendations in February 1974.

Research Progress

Researchers rely primarily on four research approaches. First, the knowledge that multiple sclerosis occurs primarily in the temperate zone has generated intensive epidemiological searches for an enviornmental factor causing the disease. Second, answers also have been sought through study of the biochemistry of the disease. For example, does the myelin of those persons who develop multiple sclerosis differ in some important manner from the myelin of those who are unaffected? Is there some modification in certain components of myelin that may be responsible for the disorder? A third approach, presently a popular one, is a search for a virus or viruses as the causative agent. Closely related is a fourth approach--that multiple sclerosis is an autoimmune disease (a disease in which the body's immune system attacks its own normal tissues as if they were invading micro-organisms). Many investigators believe that a virus activates the autoimmune process.

Epidemiology

Investigations into the prevalence of multiple sclerosis throughout the world are uncovering fascinating patterns of distribution of the disease, indicating that a factor or factors associated with certain environments may cause it. Epidemiologists have found that the risk of developing multiple sclerosis is lowest among populations living near the equator and that the risk tends to increase progressively with distance away from it. The disease is most frequent among populations living between latitudes 40° and 60° (both in the northern and southern hemispheres).

Studies in Israel, Hawaii, South Africa and the United States indicate that multiple sclerosis is probably acquired before adolescence and that the critical exposure period may be prior to 15 years of age. Individuals migrating from a high to a low multiple sclerosis risk area after about age 15 seem to carry their "high risk" with them, whereas individuals migrating before this age show a low rate of multiple sclerosis, like the native population in the low risk area.

NINDS investigators have nearly completed preliminary plans for a study of the population of the Shetland and Orkney Islands. The prevalence of multiple sclerosis on these islands is at least 200 per 100,000 which is two and one-half to three times higher than the rates in any other known population. Institute scientists believe that a thorough epidemiological survey of these island groups may reveal conditions which predispose the population to the extraordinary high rate.

An epidemiological survey of 600,000 government workers and their dependents in Mexico City uncovered only nine patients with multiple sclerosis. The incidence rate of this population, 1.5 per 100,000, is one of the lowest reported anywhere in the world.

The multiple sclerosis rates in Japan are similar to those in Mexico. Both countries are relatively less advanced than the United States and other industrial countries in environmental sanitation. This provides support to the hypothesis that environmental sanitation is inversely related to the frequency of multiple sclerosis, a situation similar to that for poliomyelitis.

Past studies have concentrated on the movement of people from high to low risk areas. New studies are now seeking to determine whether the reverse findings will prevail when people move from low to high risk areas.

Originally from a low risk section of the world, Vietnamese have been moving to France (a high risk zone) at least since World War I. An estimated 75,000 Vietnamese now live in and around Paris. A study supported by the National Multiple Sclerosis Society is underway to determine whether those who migrated before and after the age of 15 years have differing prevalence of multiple sclerosis and whether rates differ between the emigrants and the indigenous population in Vietnam.

Recent additional evidence was found indicating that multiple sclerosis is associated with environmental factors the patient is exposed to early in life. Death rates were studied among four groups in California and the State of Washington: native-born, migrant white, Japanese and Chinese. The multiple sclerosis mortality among native-born Washingtonians was higher than among native-born Californians. Few multiple sclerosis deaths were found among Japanese or Chinese in either State, whether American- or foreign-born. This suggests that racial factors may influence susceptibility.

Migrants to both States from areas reported to have low rates of multiple sclerosis had low rates, suggesting that they had acquired protection before migration. Migrants to Washington from reportedly high rate areas had higher rates than similar groups migrating to California. These findings suggest that causative factors may still be operative in the third and fourth decades of life in high risk areas and that a protective factor may also be involved in the origins of multiple sclerosis. An expanded study in Washington and California is being supported by NINDS.

In another study involving possible racial influences in susceptibility to multiple sclerosis, the prevalence among Blacks was significantly lower than among Caucasians, but higher in the North than in the South.

These patterns of age and geography have led many scientists to conclude that some infectious agent is involved in initiating the disease.

The Search for a Viral Agent in Multiple Sclerosis

Although there is considerable indirect and incomplete evidence that multiple sclerosis may be caused by an infective agent, probably a virus, no such agent has yet been identified. Studies into a viral cause of multiple sclerosis follow two approaches. One is comparative study of the infection of the central nervous system of animals by "slow" or latent viral agents which are similar to viruses but lack many of their characteristics. The second is study of the delayed neurologic effects of infections in childhood and early life on the CNS of both man and animals.

Slow Virus Research

In 1961, the NINDS established a large program for the study of slow, latent, and temperate viruses. Scientists have successfully transmitted to primates two subacute degenerative diseases of the central nervous system of man, kuru (hereditary in certain families) and Jakob-Creutzfeldt disease (mental deterioration in early or middle life). These fatal, progressive neurological diseases have been shown to be caused by very similar, unconventional viruses. Together with the animal diseases, scrapie and transmissible mink encephalopathy, these diseases have been classified as being caused by a new group of infectious agents which characteristically produce degenerative disease of the brain in animals and humans.

It has been demonstrated that each of these diseases is caused by a filterable infectious agent and is associated with an exceptionally long incubation period of months or years. Recently, for example, NINDS scientists observed kuru in a rhesus monkey eight and one-half years after it had been inoculated with the virus. This group also recently reported on the transmission of scrapie (a brain disease of sheep and goats) to the cynamologus and squirrel monkeys. This demonstrates for the first time that scrapie can infect sub-human primates. Also, development of scrapie in the squirrel monkey provides, for the first time, an experimental host susceptible to all four of these diseases.

This NINDS laboratory's reports on the transmissibility of Jakob-Creutzfeldt disease, previously thought to be rare, have recently resulted in the acquisition of brain specimens from more than 100 new victims--more than doubling the world's previously reported cases. It is hypothesized that other brain diseases may be caused by similar agents. These include the so-called presenile and perhaps even senile brain deterioration in man, such as Alzheimer's disease and Pick's disease, as well as multiple sclerosis, amyotrophic lateral sclerosis, Huntington's chorea, and progressive supranuculear palsy. The NINDS scientists believe that more definitive information on the nature of the agents causing kuru and Jakob-Creutzfeldt disease may help them find the causative agents of the others.

Small laboratory animals, such as rats, Syrian hamsters, guinea pigs and rabbits, hens, ducks, and dogs have not been susceptible to either kuru or Jakob-Creutzfeldt disease. However, NINDS scientists have now one domestic cat that has developed Jakob-Creutzfeldt disease 30 months following inoculation. The recent transmission of kuru to marmosets and adaptation of the virus in this animal, resulting in a lowering of the incubation period from 36 months on primary passage to 42 days on serial passage, provides the most sensitive test model to date for characterizing kuru. Thus, the host ranges of the viruses of kuru and Jakob-Creutzfeldt disease have been extended, and there is reason to hope that the agents may eventually be adapted to small, inexpensive laboratory animals and that the disease will then have a shorter incubation period.

Tissue studies of animals in which these diseases have been induced have resulted in the isolation of over 200 virus strains. However, the biological nature of the viruses causing spongiform encephalopathies has not yet been determined.

Additional support for a viral cause in neurological diseases in man and animals comes from the demonstration of a viral agent in visna (a demyelinating disease in sheep). One NINDS grantee is exploring the possibility that visna-like virus may be linked to multiple sclerosis in humans. Preliminary observations have indicated that the white matter of brain tissue from multiple sclerosis patients contains an enzyme found in the visna virus but not in the normal brain. Consistent demonstration of such a virus-related enzyme in multiple sclerosis brains would imply that a virus with properties similar to visna may cause multiple sclerosis.

The demonstration that non-inflammatory chronic degenerative and hereditary CNS disorders can be caused by a virus has greatly stimulated the search for possible virus origins of the demyelinating and sclerosing CNS diseases.

NINDS grantee investigators recently devised a simple technique for rapid identification of a group of small viruses called papovaviruses in patients with progressive multifocal leukoencephalopathy (PML), a subacute demyelinating disease. Their technique, which uses brain samples, eliminates the problems of contamination and recombination inherent in the tissue-culture methods used for virus isolation. It may be possible to extend this procedure to study "slow" virus infections.

Is Multiple Sclerosis An Unusual Response to a Common Virus?

Four years ago NINDS scientists and grantees succeeded in isolating a measles (rubeola) virus in patients with subacute sclerosing panencephalitis (SSPE), a fatal disease of children. Apparently a defective measles virus "smolders" or lies dormant in the body for many years after an acute measles infection. Success in isolating the measles virus in SSPE has renewed speculation that common viruses could also be involved in more prevalent neurological disorders, including multiple sclerosis.

A number of investigators have noted that levels of antibodies to the measles virus are slightly more elevated among multiple sclerosis patients than other viruses tested. In one study immune reactivity levels evaluated in serum samples from multiple sclerosis patients were higher than those from usual control subjects for measles, influenza C, herpes hominis, parainfluenza type 3, mumps and varicella. However, among multiple sclerosis patients immune reactivity levels were not higher for any of these agents than those in samples from their siblings. These data point to a familial effect and indicate that an immune response may somehow play a role. These differences must be interpreted cautiously because of the difficulty in accurately matching control subjects with multiple sclerosis patients. Why does the measles virus exist in the brain of an SSPE patient without being driven out or destroyed by the host's defense systems? The ability of a virus to exist in a suppressed state may indicate a deficiency in the immune system of the SSPE victim. An epidemiologic study of SSPE showed that more than 50 percent of patients had had measles before the age of two years and that the average time from the measles infection to the development of SSPE was six years, again suggesting a possible immature or defective immune system.

Joint research of investigators at NINDS and Georgetown University have led to highly specific new tests for cellular immunity to virus infections such as measles and German measles. These tests are valuable in studies of immune deficiencies in patients with chronic infections of the nervous system. New findings indicate suppressed cellular immunity in rubella and SSPE.

Other studies point indirectly to the possible role of common viruses in the multiple sclerosis process. For example, antibodies against the virus used in smallpox vaccination have been found in the cerebrospinal fluid of some groups of multiple sclerosis patients. These antibodies have never been identified in the spinal fluid of individuals without multiple sclerosis.

An exciting recent development was the recovery of parainfluenza virus from the brain tissues of two patients who died of multiple sclerosis. The scientists (German and American) used a technique of fusing DNA (gene material) from the brain cells of the patients with the DNA from kidney cells of an African Green monkey. Two other groups (British and Australian) have produced supporting evidence. The recovered viruses are now being inoculated into newborn primates and into "germ-free" primates as well, to determine their potentiality for producing disease. Research into a viral cause of multiple sclerosis would be advanced significantly if some form of disease related to multiple sclerosis could be induced.

This past year NINDS scientists have utilized the powerful new technique of immuno-electron microscopy to study an acute case of multiple sclerosis and have found particles which resemble paramyxoviruses. Although the finding is of uncertain significance, the investigators are devising ways to make the identification more specific. Three brain specimens from multiple sclerosis patients have been submitted to procedures for virus isolation and no virus was recovered by routine techniques. New isolation methods are now being employed.

If a virus is responsible for multiple sclerosis, it may be possible to develop a drug or other treatment methods for suppressing it. Although there are few drugs which are active against viruses, a new method of dealing with these agents has recently been devised, utilizing the transfer factor. This is an extract of sensitized lymphocytes which transfers cellular immunity from an immune person to one who lacks the immunity.

Cellular immunity plays an important role in fighting viral infections. It can be postulated that the person who develops multiple sclerosis is one who lacks cellular immunity to the infecting virus, whereas normal individuals do not develop the disease because they have the immunity.

If this is true, it is theoretically possible to use transfer factor from normal subjects to give the patients with multiple sclerosis the immunity they need to reject the infecting virus.

Autoimmune Theory

Current research in multiple sclerosis is based on the assumption that the characteristic injury to the myelin sheath is the result of a misdirected attack against the myelin by the patient's own immune system. Either cellular or humoral immunity, or both, may be involved.

Several findings point to the involvement of an immune mechanism. One is that lymphocytes (a type of white blood cell that both attacks invading micro-organisms and produces antibodies) are frequently present at the edge of multiple sclerosis plaques, or scars. A second is that an antibody fraction called immunoglobulin G, is increased in the spinal fluid of multiple sclerosis patients. Scientists recently discovered an unidentified substance in the blood of some multiple sclerosis patients that appears to be toxic to circulating lymphocytes, cells associated with specific immunity. The exact nature of this "lymphocytotoxic" factor and its possible significance for multiple sclerosis is the subject of ongoing research.

Interest in the possibility that multiple sclerosis is an autoimmune response comes from analogy with the animal disease, experimental allergic encephalomyelitis (EAE), and its closest human counterpart, postvaccinal encephalomyelitis. EAE, used for many years to study the role of the immune system in multiple sclerosis, is produced in rabbits by injection of an antigen. This antigen may be a mixture of a bacterial extract that promotes immune response (Freund's adjuvant) with CNS tissue from another rabbit, the basic protein component of myelin, or even certain synthetic fragments of the myelin protein molecule.

The controversy over the applicability of EAE to multiple sclerosis continues among researchers. Some, but not all, similarities in the clinical and pathological features of EAE and multiple sclerosis have suggested the possibility of a common origin. Both are inflammatory diseases: there is similar destruction of myelin, and the EAE affected animal exhibits neurological symptoms similar to those in human multiple sclerosis patients. EAE is known to be an autoimmune disorder and there is recent evidence which suggests that a single dominant gene is associated with susceptibility to it. The important difference between multiple sclerosis and EAE is the nonprogressive course of the latter, with lack of the recurring relapses and remissions so characteristic of multiple sclerosis.

Additional work with EAE is now under way by investigators in an attempt to understand more about the body's immunologic defense system. For example, California investigators recently developed a test which they have used to determine the presence of cellular immunity in the animal disease. They are now adapting this test to define the immunological mechanisms of multiple sclerosis.

Recently the specific chemical segment of myelin protein responsible for EAE was discovered. There are now reports that this same basic myelin protein can suppress and even "cure" EAE. A synthetic agent called Copolymer 1 apparently is capable of suppressing EAE in both guinea pigs and rabbits, but will not cause EAE in either species of animal.

It is hoped that a more precise understanding of the autoimmune processes in EAE may bring scientists a step closer in the conquest of multiple sclerosis.

AMYOTROPHIC LATERAL SCLEROSIS

The Problem

Amyotrophic lateral sclerosis, also known as ALS or motor neuron disease, is a progressive disease involving the nerve cells and their associated myelinated nerve tracts. The cause of the disorder is unknown, and at the present time there is no effective treatment. The rising number of ALS cases being reported may reflect an actual increase or possibly more sensitive diagnostic techniques. The number of ALS patients in the United States is estimated at from 6,000 to 10,000.

Throughout the world, the rate of ALS in males is from 1.2 to 2.5 times higher than the female rate. This consistent increased susceptibility among males is unexplained but may hold a meaningful clue to the etiology of the disease.

First symptoms of ALS most often appear between the ages of 40 and 70 years. Initially the patient will show muscle weakness and wasting, and irregular muscle twitching of the upper extremities. The weakness is due to degeneration of the motor cells in the spinal cord and brain which should carry messages for action to the muscles. The course is progressive but the rate of progress is variable. The average course is three to four years but some individuals remain active for 10, 15, or more years, with short periods of apparent arrest of the disease. Present therapy is limited to the temporary relief of the symptoms.

Research

The NINDS has directed extensive research relating to ALS for many years. At the present time, ALS studies are conducted at a center on Guam. Clinical and basic research, including a latent virus investigation, is being carried out at Bethesda. The Institute also supports ALS research at medical centers throughout the Nation and in Japan.

There apparently are three types of ALS. The most common form is sporadic ALS. A second form is familial. These suggest dominant inheritance.

The Institute is focusing attention on the island of Guam and certain of the nearby Marianas, where a possible third form of the disease has been observed, with an incidence approximately 50 times higher than in the United States.

A peculiarity of the Guam situation is that ALS appears with another fatal disease of the central nervous system, parkinsonism-dementia. The relationship between ALS and parkinsonism-dementia remains obscure. The finding of two neurologic diseases in one population is remarkable and suggests that common factors are involved.

The striking concentration of ALS among the Chamorro people of Guam has attracted the attention of the medical world since the early 1950s. Since 1956, the NINDS has maintained a research center on Guam devoted to the study of ALS, parkinsonism-dementia (PD) (a disease that is unique to Guam), and other neurologic disorders found in Guam and the Trust Territories of the Pacific.

Extensive studies conducted over the past 20 years have not revealed the causes of these diseases and the reasons for their remarkable concentrations. Approximately one in ten Guamanian deaths of persons over age 25 is from ALS and another one in ten is from parkinsonism-dementia.

Since 1963, in collaboration with the Institute's slow virus laboratory, scientists have been exploring the possibility that ALS may be a slow virus infection. Material from 22 Guamanian patients has been inoculated into chimpanzees, several species of smaller sub-human primates and other laboratory mammalian hosts. In no animals has neurologic disease developed. Studies using brain material in tissue culture as well as lymphocyte transformation studies are in progress. As yet, no evidence of infection has been found although recent studies using techniques utilized in cancer virology offer promise.

Ten years of study of the Guamanian population has indicated that the disease is not inherited in any known genetic pattern although more subtle genetic factors may play an indirect role. It has been discovered that many dying without evidence of neurologic disease have neurofibrillary degeneration in their brains similar to that among victims of ALS on Guam.

Investigations into the role of environmental factors in ALS have been included in the Guam studies. Two nutritional factors which have received particular attention, manganese and the cycad nut, have now been largely discounted. Although manganese is present in high concentration in the soil and drinking water on Guam, the levels are higher in many other areas of the world where Guamanian ALS and PD are not found. Also, in relation to the cycad nut, the incidence of the disease has not markedly decreased although the consumption of this nut as a staple in the diet has virtually disappeared.

Evidence is also accumulating that exposure to the Guamanian environment does not increase a non-Chamorro's risk of developing ALS. A study of veterans serving on Guam did not indicate an increase of deaths due to ALS, and a study of 12,000 construction workers who resided on Guam for various periods has not revealed a high rate of ALS. Some investigators now hypothesize that the Guamanian population may have genetic susceptibility to a factor such as an infectious agent.

Other intensive studies of possible environmental factors have been made on the Kii Peninsula of Japan where the Guamanian form of ALS is 25 times higher than in all other areas of Japan. The search for possible causes includes uses of neutron activation analysis for trace metals and systemic chemical and histochemical studies to determine the content of manganese, copper, zinc, aluminum and calcium in human nervous system tissue obtained from autopsy cases, and in the food and drinking water in high risk areas.

Aside from Guam and Japan, the prevalence rates of ALS are surprisingly similar throughout the world. In a recent study, rates in migrants from various areas of the United States to California and Washington State were identical with those of native-born Californians and Washingtonians. This finding is in marked contrast to the rates of multiple sclerosis in the same populations, in which latitude of place of birth markedly influenced the rates among both native-born and migrants.

Most recently researchers at the Reed Neurological Research Center at the University of California at Los Angeles reported a "toxic factor" in sera of ALS patients that selectively destroys nerve cells in cultures of mouse spinal tissue. Identification of the factor, which appears to be protein, might help to explain the development of ALS. Investigators at NINDS are attempting to reproduce these findings. It is hoped that the technique can be applied as an epidemiologic tool, and serve to elucidate the pathogenic events leading to the disease.

ALS Clinical Trials

No satisfactory treatment for ALS exists, despite empirical testing of the effect of numerous agents, including prednisone, guanidine, normal plasma, a presumed antiviral agent, dietary supplements, and lipoic acid.

There is now convincing evidence that central nervous system dopamine metabolism is depressed in both Guamanian and classical sporadic ALS. Administration of L-Dopa to 10 ALS patients resulted in dramatic increases in dopamine metabolism, but no clinical improvement. This abnormality is the first metabolic defect observed in ALS patients, but its significance remains obscure.

A clinical trial of treatment with the nerve growth factor (NGF) is being conducted by the Veterans Administration. This agent is known to have potent neurotrophic actions in experimental animals.

Reports that guanidine may slow the rapid progression of ALS are inconclusive and await more thorough evaluation. Trials with isoprinosine have been negative both on Guam and in the United States.

ALS Disease Model

Indications that certain wild mice may be a potential animal model for studying a viral cause of ALS come from one NINDS-supported study. The mice, which harbor a C type virus, develop a progressive subacute central nervous system disease with motor weakness in the lower extremities. Virus isolated from brains of affected mice has been purified and concentrated and serially transmitted to other mice. This virus has recently been injected into several species of sub-human primates but the outcome of this research has not yet been evaluated.

SOCIAL AND REHABILITATION SERVICE

Rehabilitation Services Administration

Because of the nature of the disease, sometimes rapidly progressive and sometimes relatively quiescent for a period of years, multiple sclerosis has been a challenging problem for workers in the field of vocational rehabilitation. Estimating ultimate employment potential is extremely difficult, and the State-Federal program of vocational rehabilitation has had limited success in serving this disability group.

The Rehabilitation Services Administration entered into a Cooperative Agreement with the National Multiple Sclerosis Society in October 1968 to consider expanding and intensifying services for the victims of multiple sclerosis. It is expected that increased coordination between State rehabilitation agencies and local chapters of the Multiple Sclerosis Society will result from this Cooperative Agreement, with the concomitant development of case findings, improvement of service techniques, and expansion of vocational opportunities for the multiple sclerotic. During 1970, representatives of the State-Federal program of vocational rehabilitation were featured speakers and active consultants at the four regional conferences of the National Multiple Sclerosis Society held in New York, Chicago, San Francisco, and New Orleans.

The Rehabilitation Services Administration has also issued a special Medical Bulletin on Multiple Sclerosis to provide the State rehabilitation agencies with current information on this disease, and to stimulate these agencies to increased efforts in rehabilitation of the multiple sclerotic, with greater use of the special program of evaluation services for a period of up to eighteen months as authorized by the Rehabilitation Act being recommended as a helpful resource. The Medical Bulletin cites a study of some 1,300 people with multiple sclerosis which shows that: 70% were able to work within the first 5 years after onset; 50% within 10 years; and that 35% were still gainfully employed between 15 and 20 years after onset.

With further advances in drug therapy, neurosurgical procedures, and rehabilitation techniques, the rehabilitation potential of those suffering with multiple sclerosis should be greater than at present. Since the larger proportion of persons with multiple sclerosis are women in the 20 to 40 age group one objective should be to accept increasing numbers for services with the vocational goal of homemaker.

Number of Rehabilitants with Multiple Sclerosis

Fiscal Year Ending June 30	Persons Rehabilitated Total	Persons Rehabilitated Multiple Sclerosis
1973	360,726	700 1/
1974 1/	375,000	700
1975 1/	394,000	1,100

1/Estimate

MUSCULAR DYSTROPHY AND THE NEUROMUSCULAR DISORDERS

The neuromuscular disorders, characterized generally by weakness, wasting, and fatigue of the muscles, generally claim children and young adults as their victims. Some of the neuromuscular diseases cause rapid death and some cause chronic paralysis and invalidism. The two most common disorders in this group, the muscular dystrophies and myasthenia gravis, afflict some 200,000 and 30,000 patients respectively. When other less prevalent neuromuscular disorders are included, estimates of the number of patients with these conditions range from 250,000 to as many as one million.

The Department's research activities in muscular dystrophy and other neuromuscular disorders are centered in the National Institute of Neurological Diseases and Stroke of the National Institutes of Health; its rehabilitation activities are the responsibility of the Rehabilitation Services Administration of the Social and Rehabilitation Service.

Obligations for programs in muscular dystrophy and other neuromuscular disorders

	1971	1972	1973	1974 estimate	1975 estimate
National Institutes of Health:					
National Institute of Neurological Diseases and Stroke...........	$5,552,000	$6,355,000	$5,841,000	$7,960,000	$7,041,000
Social and Rehabilitation Service:					
Rehabilitation Services Administration:					
Basic State Grants.	1,000,000	559,000	609,000	630,000	1,340,000
Total.............	6,552,000	6,914,000	6,450,000	8,590,000	8,381,000

NATIONAL INSTITUTES OF HEALTH

National Institute of Neurological Diseases and Stroke

At the National Institutes of Health in Bethesda, Maryland, clinical studies on muscular dystrophy, myasthenia gravis, and other neuromuscular disorders are centered in the National Institute of Neurological Diseases and Stroke's intramural Medical Neurology Branch. Multidisciplinary research is aimed at chosen target disorders, evolving basic research techniques and applying them to clinical neurological problems.

The NINDS also supports some 122 research grant projects, related directly to neuromuscular disease, in numerous hospitals, medical schools, and universities. The Institute also is continuing its support of a PL-480 collaborative research program in neuromuscular disease with the Warsaw Medical Academy, Poland.

The Institute works closely with the Muscular Dystrophy Associations of America, Inc., and the Myasthenia Gravis Foundation. These two voluntary health agencies also support research in related neuromuscular disorders.

The Problem

The muscular dystrophies are a group of chronic, inherited disorders characterized by progressive weakening and wasting of the skeletal or voluntary muscles. Most types of muscular dystrophy (MD) are inherited, but any may occur spontaneously in a family as the result of a mutation or new genetic change.

As the disease progresses a patient may be confined to a wheelchair or have difficulty performing the ordinary activities of living. Death usually results from an infection leading to respiratory failure, or to heart failure in some cases.

There are three principal types of muscular dystrophy. Duchenne muscular dystrophy, which is probably the most common type, affects male children almost exclusively and appears when they are between ages 2 to 6. Since it is a sex-linked, recessively inherited disorder, a woman who is a carrier of the trait has one chance in two that each male child born to her will be affected, and one in two that each female child will be a carrier like herself.

The first symptoms in Duchenne are a waddling gait and difficulty in climbing stairs or in rising from the floor due to pelvic girdle muscle weakness. Later, shoulder girdle muscles become affected. The disorder progresses without remission until death occurs, usually within 10 to 15 years, although some patients live considerably longer.

A second type of muscular dystrophy, facio-scapulo-humeral MD, affects the muscles of the face and shoulders. It can be transmitted as a dominant trait. That is, if either parent carries the gene for this type of muscular dystrophy, each child born, male or female, has a 50 percent probability of being affected.

A third type, limb-girdle muscular dystrophy, affects the muscles of both the pelvis and shoulders. When both parents are carriers of the defective gene, each of their offspring has a 25 percent chance of inheriting the disorder and a 50 percent chance of being a carrier. Limb-girdle MD strikes between the first and third decade of life and its progress is sometimes rapid.

Variant types also exist. Myotonic muscular dystrophy is an autosomal (not sex-linked) dominant disease beginning in young adulthood and characterized at first by stiffness in the limbs and inability to relax the handgrip, and later progressing to severe disability from muscle weakness and wasting. It also affects several other body tissues, including the heart, the lens of the eye, the testicles, and the brain.

Muscular dystrophy of late onset becomes noticeable in the fourth or fifth decade and affects both sexes. The first sign of the disease is weakness of muscles of the pelvic girdle. Its course is variable.

Diagnosis

Accurate diagnosis of the specific type of muscular dystrophy is vital since patients with other closely related neuromuscular diseases that simulate MD can be treated successfully, even though there is no treatment yet for any type of MD. In addition, accurate diagnosis facilitates evaluation of any treatment and aids the physician in his efforts to counsel the patient and his family.

The Muscular Dystrophy Associations of America, Inc., through a nationwide network of 130 clinics, offer differential diagnosis free to anyone suspected by his physician to be suffering from MD or related neuromuscular disorders.

Sophisticated methods developed through research are providing scientists with increasingly more detailed knowledge of the various muscular dystrophies and are leading to improved diagnosis. Diagnosis is usually based on the combination of clinical examination, family history, microscopic examination of muscle samples (biopsies), electromyography (recording of the muscle's electrical activity) and determination of levels of creatine phosphokinase (CPK) (the enzyme that leaks out of damaged muscle tissue) in the blood.

Recently NINDS grantees observed abnormally elevated protein synthesis in muscle tissues of patients with Duchenne muscular dystrophy. This finding has already spurred development by these investigators of a promising differential diagnostic test and a carrier identification test. When these scientists applied the techniques to patients with facio-scapulo-humeral (FSH) MD, they found that the increased protein synthesis was specific to Duchenne-type muscular dystrophy, but abnormal protein synthesis was observed in the muscle of FSH patients. These findings undoubtedly will facilitate diagnosis of these disorders and may provide some clues to their cause, which remains unknown.

Most recently one member of this team developed a simple test to help diagnose Duchenne MD in newborns. The procedure, which measures creatine phosphokinese in a drop of dried blood, appears to be significantly more effective than standard CPK measurements. Preliminary tests with 30 subjects yielded almost complete success. Standard CPK measurements achieve about 60 percent success. Such an accurate test could prove quite useful in counseling the carrier mother in her later pregnancies.

Another team of NINDS grantees has also found a protein synthesis pattern that appears to be characteristic of a benign form of muscular dystrophy called Becker muscular dystrophy. Usual laboratory tests are not useful in distinguishing between Becker and Duchenne MD.

Muscle biopsy has proven valuable both as a diagnostic technique and as a research method to learn about muscle fibers in their normal and diseased states. Normal human muscle fibers are of two basic types--Type I and Type II fibers--which usually are evenly distributed. NINDS scientists recently found that in myotonic dystrophy (a hereditary muscle disorder of young adulthood), there is a reduction in the size of Type I fibers and an increase in the size of Type II fibers. This change is relatively specific for myotonic dystrophy.

In hypokalemic periodic paralysis (a disorder of the young characterized by attacks of weakness) no alterations were found in the Type I fibers, but Type II fibers showed atrophy in approximately half of the cases.

In several nonprogressive congenital, familial muscle disorders, accurate differential diagnosis is important because their course can vary dramatically and because both genetically dominant and recessive types are found. Diagnosis of this group is made almost exclusively by muscle biopsy because clinical signs are nonspecific.

NINDS scientists recently developed "open-biopsy electromyography"-- the first technique to give direct correlation of electrical activity with histochemistry of muscle fibers. With this procedure the electromyography apparatus is brought into the operating room. The electrical activity of the muscle fiber is recorded, the muscle tissue sample is excised and prepared for histochemical study.

Treatment

No real cure is known for any of the muscular dystrophies. Antibiotics to control infections, however, have lengthened life in many patients, and physical therapy has increased the mobility of these patients and has enabled them to lead more active lives. In the past, search for a specific drug therapy has led to evaluation of such diverse agents as vitamins, amino-acid mixtures, nucleotides, and anabolic steroids. None has been shown to halt the progression of the muscle weakening. Important nonspecific treatment includes physical therapy, which may delay the shortening of the muscles, use of braces, walkers, special shoes, and corsets to partially compensate for muscle weakness, certain surgical procedures on muscles, special schooling, and special summer camps for afflicted children.

Duchenne MD, because of its hereditary nature, is most successfully prevented by detecting female carriers of the Duchenne MD gene and then providing genetic counseling before they bear children. It is now possible to determine fetal sex by sampling the pregnant woman's amniotic fluid and studying the chromosomes in the harvested cells. If the unborn child is a male, a mother who knows she is a carrier can be alerted and given an opportunity to decide if she wishes to terminate the pregnancy.

The drug hexahydrocoenzyme Q4 which earlier was reported as potentially useful in treating MD has proven disappointing in tests conducted over several years in a collaborative NIH-supported study. Nevertheless, the testing protocol developed for this project is expected to be of continuing benefit to scientists since it will shorten the time required to evaluate any other proposed treatment.

Other grantee scientists recently discovered abnormal concentrations of a catecholamine-like compound in muscle fibers taken from Duchenne patients. Because this substance accumulates before gross and presumably irreparable damage to the fiber takes place, the investigators suggest that a number of drugs to prevent such accumulation may be of value in treating Duchenne dystrophy.

Research to Identify Carriers

Significant advances in recent years have increased the number of identified carriers of Duchenne MD and simplified detection. NINDS grantees recently reported a new technique that may significantly enhance the precision of carrier identification in certain cases. By coupling the new test, based on abnormal muscle protein synthesis, with creatine phosphokinase (CPK) measurements, the scientists were able to identify more than 90 percent of the Duchenne carriers, compared to between 66 percent and 80 percent using CPK evaluations alone.

Other methods of detecting carriers of Duchenne and other forms of MD are being explored. NINDS scientists, for example, have found that muscle samples taken from carriers of Duchenne MD show degeneration and regeneration of scattered grouped muscle fibers.

Abnormal structural changes in the muscle fiber of Duchenne carriers may provide additional clues for identification of these individuals. Electron microscopic observations of fibers supported diagnoses by other methods and identified cases in which no other laboratory evidence was yet available.

Scientists recently reported that pregnancy itself may influence serum CPK levels. Since many carriers are first seen by physicians when they are already pregnant, the scientists suggest that normal values in suspected carriers during pregnancy should be interpreted with reservation, and the women retested after delivery.

Search for Underlying Cause

Historically, the causes of the various forms of MD have been looked for in the muscle itself. However, failure to find the seat of the disease in the muscle has led some investigators to look elsewhere. Recent work with muscle transplants in chickens led one investigator to conclude that development of muscular dystrophy in chickens is due to a disease of muscle cell metabolism. It is not clear what relation animal dystrophies may have to the human muscular dystrophies.

NINDS investigators have developed a new hypothesis for the cause of Duchenne MD. They believe that muscle damage may be produced by abnormalities of the small (arterial) blood vessels within the muscles rather than by a defect in muscle fiber itself. They further postulate that such blood vessel abnormalities may become apparent only when certain blood vessel constricting agents are present.

These scientists have been able to reproduce early and midstage characteristics of Duchenne muscular dystrophy in rats by tying off blood vessels and using drugs to constrict the vessels. Neither procedure alone, however, caused significant changes in the muscle fibers. They recently found that following each dose of vasoconstrictor agent the serum muscle enzymes rise, as in Duchenne MD. These scientists are now using this test to screen for drugs that might be effective clinically in preventing muscle ischemia.

Other NINDS scientists found evidence linking Duchenne muscular dystrophy with a defect in a chemical mechanism that appears to cause prolonged blood-vessel constriction, which prolongs reduction of blood flow to the muscles.

Another recent study by NINDS grantees reaffirms that a nonprogressive, generalized mild or moderate decrease of intellectual function often coexists with Duchenne muscular dystrophy. The scientists speculate that a single gene, with expression in both muscle and brain, may be the cause.

A British research team recently found evidence of a neuronal abnormality in a form of dystrophy seen in mice. They reported that dystrophic muscle behaves normally when regenerating in culture in the presence of normal spinal cord tissues but is abnormal when coupled with spinal cord samples from dystrophic mice. Whether there is a similar mechanism occurring in the human disease remains uncertain.

Significant reduction in the activity of troponin (a protein that plays a crucial role in muscle contraction and relaxation) in patients with Duchenne disease was reported by other grantees. The decrease may be directly related to the impaired functioning of the affected muscle. In other muscular diseases, troponin activity remained normal.

In a recent study by NINDS grantees, chemical by-products of muscle degeneration were seen only in Duchenne patients where CPK activity exceeded certain levels, suggesting that the activation of muscle degeneration occurs as a result of CPK leakage from diseased muscle.

Scientists from several NIH laboratories recently confirmed the finding by others of an abnormally high insulin response to orally administered glucose in patients with myotonic muscular dystrophy. The investigators reported the response does not appear to be related to muscular wasting. They concluded that abnormalities of insulin secretion are common in these patients and measurement of them may help detect myotonic muscular dystrophy.

NINDS researchers continue to gather evidence that the muscle weakness and atrophy in myotonic dystrophy and related disorders are caused by an abnormality of the motor nerve connecting to the muscle, rather than the muscle itself. These researchers have found evidence that myotonic congenita and paramyotonic congenita result primarily from abnormalities of nerve rather than muscle fibers.

These hypotheses, developed at NINDS in an effort to differentiate between primary disorders of nerves and the muscle disorders, may lead to discovery of the precise cause of these various disorders.

POLYMYOSITIS AND DERMATOMYOSITIS

Two muscle diseases which sometimes simulate MD are now treatable. Polymyositis and dermatomyositis are inflammatory disorders of the muscle and skin, characterized by elevated muscle enzymes, such as creatine phosphokinase (CPK), circulating in the serum. These disorders, if left untreated, often are steadily progressive and fatal.

Corticosteroids were found by NINDS scientists six years ago to control the inflammation and promote improvement. NINDS grantees recently reported that treatment with methotrexate (an anticancer agent) may prove valuable for polymyositis patients who are resistant to corticosteroid therapy. Two other immunosuppressants, azathioprine and 6-mercaptopurine, have also been used successfully. Evidence of an immune reaction causing vascular injury in dermatomyositis of childhood, which was earlier reported by NINDS scientists, has now been confirmed by others.

HYPOKALEMIC PERIODIC PARALYSIS

NINDS scientists have demonstrated dramatic improvement for as long as seven years in patients with hypokalemic periodic paralysis who were treated with acetazolamide. The disorder is characterized by attacks of paralysis, usually beginning in childhood or adolescence, at daily to early intervals.

MYOPHOSPHORYLASE DEFICIENCY

NINDS investigators recently were able to provoke production of the enzyme myophosphorylase in the muscle fibers of patients suffering from myophosphorylase deficiency. The "revival" of this enzyme which is essential in sugar metabolism occurred when the muscle cells were regenerating after injury. This development was a surprise since it had generally been considered to be genetically absent. It is now hoped that therapeutic efforts can be directed toward promoting production and retention of myophosphorylase in mature fibers. Conceivably this approach could apply to other genetic enzyme deficiencies as well.

DISCOVERY OF NEW DISEASES

Last year NINDS researchers reported the discovery of two disorders, a non-progressive (benign) muscle disorder called benign congenital hypotonia with Type II fiber predominance, and a syndrome characterized by abnormalities in the muscle fibers in conjunction with paralysis of the eye muscles. Investigators have designated this latter disorder "oculocraniosomatic neuromuscular disease with ragged red fibers." This past year the scientists reported observing similar abnormal muscle fibers in a new hereditary syndrome consisting of limb-girdle dystrophy, myoclonus epilepsy, and elevated lactates and pyruvates that can be fatal in childhood.

A rare new myopathy--carnitine deficiency--was recently described by NINDS grantee investigators in Minnesota. Carnitine, a component of muscle tissue, was found to be absent in the skeletal muscle of a patient with progressive muscle weakness. Prednisone therapy improved the patient's weakness. The reason for the carnitine deficiency is not known.

A NEW NOMENCLATURE FOR HUMAN MUSCLE FIBER (HISTOCHEMICAL) TYPES

A new nomenclature for human muscle fiber histochemical types has been submitted by NINDS scientists to the World Federation of Neurology for consideration.

MYASTHENIA GRAVIS

Myasthenia gravis (MG) is a chronic neuromuscular disease that generally appears between ages 15 to 35 years in females, and ages 40 to 70 in males. It is characterized by weakness and abnormally rapid fatigue of the voluntary muscles, with improvement following rest.

There have been significant reductions in the death rate and degree of illness in MG patients, even in the most severe cases, during the past two decades. Improvements in support systems, such as intensive hospital care, respirators and antibiotics, and widespread use of tracheotomy (surgery to open the windpipe) undoubtedly have contributed, but the main advances have been in the use of anticholinesterase drugs and adrenocorticotropic hormone (ACTH). Although the cause of MG is still debated, and therapy is directed partly toward the treatment of symptoms, MG is one of the most successfully managed neuromuscular disorders.

Formerly many MG patients died within the first few years of their illness. Today scientists believe the majority of patients will live out a normal life-span, and an estimated three-fourths of moderately affected MG patients can lead virtually normal lives.

Diagnosis

Diagnosis of severe myasthenia gravis can usually be made without difficulty on the basis of history and physical examination alone. MG may affect any voluntary muscle, but usually involves those of the eyes, face, lips, tongue, throat, and neck more severely than others. Involvement of muscles of breathing and limb movement can also be severe.

Symptoms may vary greatly depending upon which muscles are affected. The disease may begin with a localized weakness, or as a severe generalized weakness. A patient may experience difficulties in breathing, swallowing, or talking, or have double vision, or arm or leg weakness. There may be unusually rapid muscle fatigue following repetition of a movement.

Confirmation of the diagnosis is achieved with drug studies as well as electrical, mechanical, and X-ray tests. Injection of a drug that facilitates nerve-muscle message transmission may result in a dramatic increase in strength. Administration of a neuromuscular blocking agent that inhibits the transmission of nerve-muscle messages causes increased weakness. Responses to these agents usually confirm the diagnosis of MG. Repetitive electrical stimulation of the nerve-muscle apparatus provides objective evidence of impaired transmission.

Study of the thymus (a gland-like organ in the chest that normally atrophies with increasing age) is often valuable. If there is diagnosis of tumor of the thymus in MG patients, this will have important bearing on both the treatment and outcome of the disease. Moreover, the role of the thymus in causing the disease is of increasing research interest.

Advances in Treatment

Basic research on the transmission of nerve impulses for muscle activation has produced an increasingly precise picture of this mechanism and has led to refinement in treatment. Several drugs provide relief from symptoms, and others may be effective against one or another cause. For nearly 40 years the anticholinesterases, especially pyridostigmine and neostigmine, have been mainstays of symptomatic treatment.

ACTH Therapy. It is well documented that ACTH (adrenocorticotrophic hormone) injections benefit severely ill MG patients. NINDS grantees earlier found that many receiving a 10-day course of daily ACTH experienced temporary muscle weakness and increased respiratory distress for the first several days before improvement began to appear. Paradoxically, the patients who experienced the greater initial weakness tended to show the more striking eventual recovery. Now investigators have found that continued maintenance ACTH injections every few days or weekly over extended periods can prolong the beneficial effect. In a study involving a large series of patients, grantees also found short intensive courses of ACTH useful in improving increased temporary weakness. Patients with moderate and severe disease were thought to benefit more than patients with mild or localized disease.

Prednisone Therapy. A new treatment introduced by intramural scientists--a high, single dose, alternate-day, oral prednisone regimen--has proven extremely beneficial over long periods in the majority of 20 patients. Prednisone is a synthetic drug whose action resembles the natural hormone, cortisone. Patients over age 40, especially males, respond best. Physicians throughout the world have confirmed the beneficial results.

The NINDS scientists now consider alternate-day prednisone the most effective treatment and believe it may suppress the disease sufficiently long for it to disappear.

Using animal nerve-muscle preparations, intramural scientists recently demonstrated an adverse interaction between prednisone and anticholinesterase drugs. These findings may help explain who some myasthenics taking both drugs show an adverse interaction between them.

New Agents. NINDS grantees are testing a group of drugs known as the germine acetates in managing MG. Patients treated for a short period exhibited improved neuromuscular function. More recently, other investigators reported favorable results from use of germine monoacetate (GMA) for outpatients over a limited time.

Thymectomy. Thymectomy (surgical removal of the thymus) proved beneficial in 89 percent of a large series of patients, most of whom were severely affected, NINDS-supported scientists recently reported.

Significant improvement also was reported in a long-term study of the surgery in juvenile patients, and other studies indicate that benefits may be enhanced with irradiation of the thymus before the surgery.

Some scientists now believe that thymectomy should be performed routinely on all MG patients, especially the younger females.

Theories on Cause

The cause of MG remains unknown, but there is agreement that the problem exists somewhere along the motor unit, which consists of the lower motor neuron (a branching nerve fiber), and the muscle fibers it activates. Many studies have centered on the junction between the axonal tip of the nerve and the muscle fibers, where nerve impulses liberate a chemical, acetylcholine, which transmits the message causing the muscle fibers to contract.

In myasthenia gravis there is a defect of that transmission, possibly due to a failure by the neuron to make acetylcholine, or to a disturbance in its release. It is also possible that MG is due to the presence of inhibiting substances in the patient's blood.

Scientists also have suggested that the cause of the transmission failure in MG may be an autoimmune disturbance in which circulating antibodies attack and damage the patient's own tissue. Some recent evidence supports this idea. This includes the demonstration that one-third of MG patients have circulating antibodies against skeletal muscle and the thymus. These antibodies are present in virtually all MG patients with thymus tumors and in some who do not have MG but do have the tumors. It is now believed that antibodies do not cause the symptoms of the disease but are an indicator of a parallel autoimmune disturbance.

Recently an NINDS grantee working with guinea pigs, concluded that inflammation of the subject's own thymus gland develops in myasthenia gravis resulting in overproduction of a postulated thymic "hormone." This proposed hormone, partially isolated, may in turn interfere with the transmission of nerve messages to muscle, thus causing weakness.

NINDS investigators now hypothesize that the defect of transmission located at the neuromuscular junction possibly is secondary and caused by an aberration in the metabolism of the nerve cell body. They suggest that a circulating factor from the thymus and related tissues may be exerting the detrimental influence.

Historically, MG has not been considered an inherited disorder, but recent studies by NINDS grantees indicate that MG occurs within families somewhat more frequently than can be explained by probability. Data from one recent NIH-supported survey indicate that susceptibility to MG perhaps provided by an environmental factor may, in some way, be an expression of a rare recessive trait.

While evaluating a receptor protein isolated from the neuromuscular junction, NINDS grantees found that rabbits injected with the protein developed weakness and paralysis resembling some aspects of human myasthenia gravis. Further evaluation of this new animal model possibly might help clarify the pathogenesis of MG and contribute to improved management of the disease.

Although the cure for muscular dystrophy and myasthenia gravis remains elusive, advances in the treatment of MG and other neuromuscular diseases give hope that an effective treatment for muscular dystrophy will some day be found. Research findings from any of these disorders or from the various basic studies of muscles or nerves often contribute to the understanding of other neuromuscular diseases.

SOCIAL AND REHABILITATION SERVICE

Rehabilitation Services Administration

Because of the nature of the disease, victims of muscular dystrophy have limited potential for gainful employment, and therefore only a small number of them have been rehabilitated through the State-Federal program of vocational rehabilitation. It is hoped, however, that the acquisition of new medical knowledge concerning this disabling condition will contribute to positive gains over the next decade in the work capacity of the muscular dystrophy case. State vocational rehabilitation agencies will be serving increased numbers of persons disabled by muscular dystrophy due to the emphasis of the Rehabilitation Act of 1973 serving the severely disabled.

Rehabilitants with Muscular Dystrophy

Fiscal Year Ending June 30	Persons Rehabilitated	
	Total	Muscular Dystrophy
1971	291,272	252
1972	326,138	313
1973	360,726	400
1974	375,000	400
1975	394,000	800

CEREBRAL PALSY AND DEVELOPMENTAL DISORDERS OF EARLY LIFE

Cerebral palsy is not a specific disease entity. Rather it is a general term covering the loss or impairment of control or coordination over voluntary muscles that results from damage to the developing nervous system before, during, or after birth. The dysfunction is not progressive or episodic, but often accompanies other handicaps.

The United Cerebral Palsy Associations, Inc., a national voluntary health agency, estimates that 750,000 persons have cerebral palsy. About 15,000 babies are born with cerebral palsy each year, or one newborn in every 200 live births.

There are many other neurological and communicative disorders which develop in early life. Some of these are genetic in origin, or may involve metabolic deficiencies. Many are progressive, resulting in death. All require major investments of both medical and social services, and exact a toll in personal anguish that cannot be measured.

The Department's research activities in cerebral palsy are centered in the National Institute of Neurological Diseases and Stroke of the National Institutes of Health; its rehabilitation activities are the responsibility of the Rehabilitation Services Administration of the Social and Rehabilitation Service.

Obligations for programs in cerebral palsy and developmental disorders of early life

	1971	1972	1973	1974 estimate	1975 estimate
National Institutes of Health:					
National Institute of Neurological Diseases and Stroke............	$14,496,000	$13,992,000	$14,944,000	$15,066,000	$13,971,000
Social and Rehabilitation Service:					
Rehabilitation Services Administration:					
Basic State Grants.	5,000,000	2,795,000	3,045,000	3,150,000	4,020,000
Innovation Grants..	28,000	---	---	---	---
Total.............	19,524,000	16,787,000	17,989,000	18,216,000	17,991,000

NATIONAL INSTITUTES OF HEALTH

National Institute of Neurological Diseases and Stroke

CEREBRAL PALSY AND DEVELOPMENTAL DISORDERS OF EARLY LIFE

Cerebral palsy occurring in infancy or early childhood, before full growth and development have been attained, generally causes more profound and irreversible handicaps than when it occurs in adults, as from strokes, or in older children after full intellect, speech, hand skills, and locomotion have been achieved.

Kinds and Degrees of Cerebral Palsy

There are six clinical types of cerebral palsy: those exhibiting spasticity, in which the muscles are under a continuous state of tension, with increased reflex activity; athetosis, characterized by disorganized spontaneous muscular movements; ataxia, manifested as a disturbance in balance while walking or standing; tremor, similar to the fine tremulousness seen in adults who have parkinsonism; and those with rigidity, a slow, sustained contraction of the muscles, leading to clumsiness; and mixed, a combination of two or more of the above types.

The degree of disability is dependent upon the site and amount of damage in the brain. Sometimes, damage is so slight that the victim may have only a mild clumsiness or incoordination of the hands, or a slight loss of balance in walking, or a minor speech impediment. In very severe cases, he may be confined to wheelchair or bed and be totally dependent upon others. At times, speech may be so involved that verbal communication is impossible. In some patients, only the right or left half of the body is affected. In others, both legs may be involved so that walking is associated with awkward or involuntary movements and irregular gait. Complete loss of hand function may make it impossible for the cerebral palsied victim to provide himself any degree of self care.

Because the brain controls so many functions other than purely motor acts, other defects are also associated with cerebral palsy. Thus, defective vision or hearing, convulsive tendencies, intellectual impairment and personality change may occur in cerebral palsy. These associated defects in some instances may be more disabling than the motor disability itself.

Management of Cerebral Palsy

For many years it was thought that almost all children with cerebral palsy were destined to exist outside the mainstream of society. Advances in medical and related therapies, vocational counseling and guidance, psychiatric and psychological counseling, recreational and social programs now indicate that over 50 percent of the cerebral palsied can be rehabilitated to function as optimally as possible within the limits of the basic handicap. Recent focus on the concept of the total child and the multidisciplinary team approach to cerebral palsy have resulted in significant progress.

Many medicines have been evaluated for their therapeutic value in the management of the spasticity associated with childhood cerebral palsy, but with little success. However, in two recent controlled studies 15 children were treated with the drug dimethothiazine, and some improvement was noted. This drug appears to be particularly useful in cerebral palsied children just beginning to walk.

Considerable attention has been focused on the development of new physical and occupational therapy techniques to improve motor function. An investigator in London working with a group of cerebral palsied children observed that motor inefficiency in the group was due in part to the basic motor disorder and in part to the general conditions of living in which exercise was not encouraged. Subsequently, a positive physical fitness program was undertaken. This included abandonment of all apparatus and any management concepts which inhibited the child from moving himself from place to place and the start of remedial gymnastics. As the children became more active and stronger, marked improvement was noted.

Speech therapy by skilled professional personnel is especially important in the management of the cerebral palsied who often experience difficulties of communication. For example, patients with athetoid cerebral palsy sometimes have difficulty coordinating speech sounds. Preliminary results indicate that in some instances patients may be trained to control some nervous system functions. Utilizing biofeedback techniques, investigators have been able to reduce the tension of facial muscles, thus aiding movement of the lips during speech. These researchers are hopeful that the improvements noted can be adopted in conversational speech.

It has also been reported that some cerebral palsied persons with speech problems that cannot be corrected medically or through therapy have been helped by a new device developed by the National Institute for Rehabilitation Engineering. The electronic device, which was first used to transmit speech from astronauts on space flights, filters, clarifies and amplifies the voice of an individual who has a normal larynx.

In certain types of cerebral palsy, braces help to reinforce muscles and prevent or correct deformity. Orthopedic surgery helps in some cases to relax muscles and to improve coordination. According to a report presented to the American Academy of Orthopedic Surgeons, injections of 40 percent alcohol into the overactive muscles of cerebral palsied individuals appears to ease spasms and to allow more effective therapy on surrounding muscles.

Another report indicates that an electronic brain pacemaker in several cases has helped to control spasticity and tremors that occur with cerebral palsy. The pacemaker is still considered experimental, and it is too early to know how long the effects will last and on which patients this treatment will work best. But even if the pacemaker's results turn out to be short lived, many scientists believe that the fact that it works at all could lead to new understanding of how the brain controls movement and perhaps to simpler nonsurgical methods of treatment of the abnormal movements.

Treating the "Disability"

A child with cerebral palsy or any other physical disability is often handicapped as much as a consequence of having a disability as by the degree and type of the disorder itself. Personality, emotional development, and educational achievement are all affected by the motor disorder, associated sensory, intellectual and other disabilities. As a result of this combination of disadvantages, progressive social deprivation and isolation often occur, and in time become the greatest handicap. An NINDS grantee is currently conducting research on the interpersonal aspect of child cerebral palsy in an attempt to learn more about how the child relates to his family and his therapists.

Inherited and Developmental Diseases

There are also a number of inherited and developmental disorders which can affect the nervous system. Although many of these are relatively rare, together they constitute a serious national health problem and an item of important expense to the community. For example, within the United States a number of children are born each year with Tay-Sachs disease, a hereditary disorder in which excess quantities of fatty materials accumulate in the brain and other organs. Total mental retardation swiftly follows the onset of the disease. These infants ultimately are cared for in chronic disease hospitals. The estimated cost for this small group alone is in excess of $30,000 per patient per year.

Tay-Sachs disease is only one of a group of inherited lipid-storage disorders, the **sphingolipidoses**, which cause some mental retardation, neurological and systemic abnormalities, and in most cases early death for the victim. In this group of disorders, enzymes required to break down all lipids are missing because of genetic defects.

Fortunately, recent research on these disorders has been fruitful. Of particular significance has been the development of procedures for positively identifying victims prior to birth. These procedures have made possible the best therapy of all--prevention.

A number of new techniques in the diagnosis and management of high-risk mother and her infant have been developed in the past five to ten years. Amniocentesis, a procedure in which a needle is inserted in a pregnant woman's abdomen to draw a small sample of fluid from the womb, has made it possible to help diagnose central nervous system birth defects. Fetal monitoring, the more liberal use of cesarean section, and utilization of different modes of anesthesia have provided better delivery care. New methods of managing complications affecting the newborn such as respiratory distress syndrome have considerably improved infant outcome. The development of a new serum for administration to all Rh-negative blood type mothers within 72 hours after each birth of an Rh-positive baby has contributed to the prevention of destructive blood incompatibility diseases, and the development and use of the rubella vaccine has resulted in a drop in birth defects due to rubella contracted by pregnant women.

Collaborative Perinatal Study

The Institute's Collaborative Perinatal Study, a prospective, long-term investigation of the relationships between pregnancy and pregnancy outcome, is now in its final phase. Major emphasis is shifting to analysis of data derived from more than 55,000 pregnancies that occurred between 1959 and 1965 in the 12 participating hospitals. These data are being analyzed to evaluate possible relationships between maternal, obstetrical, and other facts and neurological abnormalities in offspring.

As analysis and interpretation of these data are completed, monograph reports will be published in book form on cerebral palsy, and a number of other specific disorders occurring in the perinatal period. A comprehensive publication, The Women and Their Pregnancies, appeared last year.

It is anticipated that careful analysis of the Study's meticulously collected data will result in clear evidence for certain causes of conditions of pregnancy and ultimately may lead to measures for prevention of birth defects.

Recent Findings of the Collaborative Perinatal Study

An interesting and unexpected finding already emerging is that certain anomalies associated with high perinatal mortality do not influence development or mortality of those infants who survive. For example, although it is now well established that maternal smoking during pregnancy increases the risk of the baby's death, scientists at one collaborating institution were not able to identify harmful long-term effects of maternal smoking on growth and intellectual development in children who survived the perinatal period.

Occurrence of a single umbilical artery is an example of a malformation known to result in high perinatal mortality, yet not adversely affecting development in surviving infants up to four years. From the results of this study, it now appears that with the exception of a higher incidence of hernias, there is no difference in the development or mortality between these infants and carefully matched infants used for controls.

Findings such as these make possible more accurate counseling of the parents of affected children. In the case of a child with single umbilical artery, parents can now be assured that once the perinatal period has passed, the outlook is as good as for another without the defect.

Cumulative Findings of Collaborative Perinatal Study

The link between prematurity and cerebral palsy and other developmental disabilities is well known. Data from the Study also show that low-birth-weight infants constitute a disproportionately large share of those suffering perinatal death and later neurologic abnormalities including cerebral palsy. In addition, the data substantiate a relationship between birth weight and factors already known or suspected of influencing it. These include low socio-economic status, extremes of maternal age, short stature, cigarette smoking, certain pathologic states, and low maternal weight gain during pregnancy. Separate NINDS studies document maternal weight gain as the most important of 32 factors influencing the weight of an infant at birth.

A number of the goals originally set by the Study therefore gradually are being realized. Several investigators suggest that if information available from the Study about factors influencing adverse outcome in pregnancy were fully utilized, the number of neurologically impaired infants could be appreciably reduced.

Long-Term Value of the Study

Because of the enormity of the Study, a massive amount of data remain to be analyzed. Some of these data are unique in their quality and completeness, their prospective nature, and in the safeguards which were imposed to assure comparability in their collection. Without doubt, they represent a national research resource for scientists investigating events of intrauterine and postnatal life that cause neurological handicaps.

Infection as a Cause of Birth Defects

Study data and specimens are also being utilized by scientists in other components of the NINDS and at medical centers throughout the country.

Using material from the Study, scientists of the Institute's Infectious Diseases Branch have contributed to understanding of the relation between perinatal infections, particularly those of viral origin, and birth defects such as cerebral palsy.

It was in part from these studies that the capacity of the rubella (measles) virus to damage the unborn babies at any time during pregnancy was established. This lent impetus to the campaign to develop a rubella vaccine. As a result of the widespread use of the vaccine, reported birth defects caused by rubella--cerebral palsy, for example--decreased from 77 in 1970 to 33 in 1972.

Today, a number of studies in the Infectious Diseases Branch eventually may produce equally significant applications. For example, simpler tests for the presence of other viral agents--Herpes I (a cause of the common cold sore); Herpes II (a cause of eczema, encephalitis, and inflammation of the vulva and vagina); and cytomegalovirus (a cause of hemorrhage, anemia, or extensive hepatic or central nervous system disorder)--are valuable because previous methods were laborious and expensive, or not specific. Approximately 1,600 sera from mothers and offspring born after abnormal pregnancies are being tested for viruses. Results will help determine what effect virus infection has on the outcome of abnormal pregnancies and provide valuable information on epidemiological aspects of virus infection.

Motor retardation and slight to moderate hearing deficits can result from mild as well as from severe rubella infection. Causes of these subtle disease entities were formerly unknown.

Scientists of the Branch are continuing their search for a rubella vaccine that could be used without risk by women of child-bearing age. In studies of pregnant women vaccinated with the Cendehill strain of the rubella virus no evidence was found of transmission of the virus to the fetuses and only rarely to the placentas, suggesting the possible more general use of the Cendehill vaccine for women of child-bearing age.

Research in Hawaii demonstrated that clinical rubella could be prevented in pregnant women exposed to this disease by early use of gamma globulin, and it appeared that congenital rubella was also reduced. Additional studies are planned to further document the effectiveness of gamma globulin.

In another study, scientists are assessing the validity and usefulness of specific tests for serum immunoglobulin (IgM) to identify antibodies to rubella, cytomegalovirus, toxoplasmosis, herpes virus, and syphilis in high risk infants. Interest centers on detecting the presence of congential infections, and in identifying infections which require treatment.

At another institution, highly specific and sensitive new tests for immunity to virus infections have been developed. It is planned to extend these tests for bedside use. The Infectious Diseases Branch is complementing these studies of human sera obtained from the Collaborative Perinatal Study with animal studies. New studies of infections in monkeys demonstrate that hydrocephalus and cataracts in the fetus result from inoculation of pregnant monkeys with Flu-A or Venezuelan Equine Encephalitis virus.

Virus Research at Grantee Institutions

The effects of viruses on the fetal nervous system are being investigated by NINDS grantees. At one institution, animal studies with hog cholera and other viruses strongly suggest that many sporadic human malformations may be induced by viruses. At another institution a grantee is studying animal viruses in their natural hosts as a means of observing virus-induced reproductive failure caused by specific tissue responses to stimuli. Study of the mechanisms responsible for protecting the fetus from viral invasion such as interferon or placentally derived antibody may supply a clue as to why some disease-causing organisms produce birth defects while others apparently have no such capacity.

Relationship of Undernutrition to Birth Defects

Prematurity has long been recognized as a cause of cerebral palsy and other birth defects. In the last few years the low birth-weight baby was also identified as being at higher risk for these disabilities. Now scientists believe that there are at least two distinct causes of low birth-weight--one maternal undernutrition, the other a restriction in the artery supplying blood to the uterus.

In a recent study supported by the National Institute of Child Health and Human Development on the effect of maternal nutrition the investigators found larger brain size in newborns of mothers who were best nourished, and that when not too severe, the retardation of the brain and other organs from fetal undernutrition is probably reversible with adequate nutrition after birth.

NINDS grantees are investigating the effects of severe undernutrition and drugs on myelin thickness. Myelin, a complex fatty substance of proteins and lipids that surrounds each nerve fiber, is essential to normal brain and nervous tissue development and functions. In a clinical study by another Institute grantee, abnormalities in myelin formation were observed in infants who had been exposed to hexachlorophene, a germicidal agent once widely used in hospital nurseries to control infections.

Drugs as a Cause of Birth Defects

Throughout the years a number of drugs have been identified or suspected as causes of developmental defects in children. Recent studies indicate that the probability of having a malformed child may be two or three times greater in epileptic women who receive diphenylhydantoin treatment early in pregnancy than in women who have not received the drug. The scientists believe that a proportion of the increased risk could be due to the epilepsy itself.

Other Suspected Causes of Birth Defects

Scientists estimate that in the overwhelming majority of cases of congenital defects the cause of the defect is unknown. For this reason numerous factors which possibly may be implicated are being studied.

For example, animal experiments which produce a wide range of serious birth defects by slightly raising the pregnant mother's body temperature have led the World Health Organization to investigate the implication for human beings. Scientists suggest that excessive heat resulting from fevers associated with common illnesses such as influenza, and with saunas and tropical climates could conceivably damage the fetus and affect the intelligence of the child.

Excessive intake of alcohol during pregnancy, maternal contact with blighted potatoes, maternal ingestion of food exposed to herbicides are other possible causes of defects being examined by NINDS and other investigators.

New Research on Known Causes of Birth Defects

NINDS scientists are trying to learn more about lead poisoning, a known cause of damage to the nervous system. An important objective is the development of an animal model which would make it easier to study new measures to remove excessive lead from tissues.

Scientists supported by the National Institute of Neurological Diseases and Stroke, the National Institute of Child Health and Human Development, and the United Cerebral Palsy Associations, Inc., are continuing studies on the nature of jaundice--a known cause of cerebral palsy. For a number of years phototherapy or blue fluorescent light treatment has been considered a relatively simple treatment for jaundice in the newborn. Work of one institution in this area is aimed at shortening the treatment and improving its safety.

In another investigation a rapid, sensitive blood test for carbon monoxide has been developed which enables a physician to observe the progress of blood diseases such as jaundice hour by hour if necessary. Although this procedure is still classed as experimental, scientists who have been involved in its development anticipate that it may lead to improved understanding and treatment of the jaundiced newborn.

Basic Research Leads to New Treatment for Hydrocephalus

Hydrocephalus, the excessive accumulation of cerebrospinal fluid within the brain, resulting in enlarged head size, affects about two of every 1,000 newborn babies. It can lead to mental retardation or even death. Heretofore, this defect has been treated surgically to drain off the excess fluid. Last year an NINDS grantee reported successful treatment of this condition simply by wrapping the infant's head in an elastic bandage. The bandaging produced increased intracranial pressure which in turn induced absorption of the cerebrospinal fluid. As a result head growth was immediately arrested and the hydrocephalus alleviated. Today, a year later, the hydrocephalic children show normal neurologic development and are free of symptoms of the disorder. This new technique, an outgrowth of the investigator's study of cerebrospinal fluid in cats, exemplified the relevance and importance of basic research to clinical practice.

Hereditary Metabolic Disorders

During the past year NINDS scientists have made important advances in treatment of hereditary metabolic diseases which affect the nervous system. In combined basic and clinical studies they succeeded in purifying the enzyme lacking in the organs and tissues of patients afflicted with Fabry's disease, one of several lipid storage diseases which can result in mental retardation and early death. By injecting the purified enzyme into the patients, these scientists were able to temporarily reverse the effects of the metabolic defect, possibly due to activation of the faulty enzyme when it becomes associated with the active injected enzyme.

Taken together, these findings provide the first signs of encouragement for the success of enzyme replacement therapy for patients with certain heritable metabolic diseases.

A second important advance is a related endeavor with another of the lipid storage diseases. After eight years of effort the enzyme missing in patients with Gaucher's disease has also been purified, and scientists are now in a position to begin assessing the efficacy of replacement therapy.

Another impressive finding during the past year was the documentation of the reliability of the prenatal diagnosis of Gaucher's disease and Niemann-Pick disease by enzyme assays performed on cultured amniotic cells. These contributions, coupled with demonstrations of the feasibility of the prenatal diagnosis of Fabry's disease and Tay-Sach's disease by amniocentesis (a procedure in which a needle is inserted in a pregnant woman's uterus to draw a small sample of amniotic-sac fluid) has made NINDS one of the most frequently consulted centers for genetic counseling. Help in this area is provided by NINDS scientists to any requesting physician.

British scientists recently reported they have succeeded in detecting severe brain and spinal cord birth defects early in pregnancy from a few drops of the mother's blood. American scientists hope to confirm this. Should this be done, it then may be possible to utilize the blood test for mass screening of all pregnant women.

Outlook for Future

Although progress in research has been steady and occasionally dramatic, there is still more unknown than known about cerebral palsy and other cerebral malformations. These problems continue to be investigated at all levels by Institute scientists and grantees in the hope that more of their causes can be identified and that eventually cures can be found. The importance of this research, scientists say, cannot be overemphasized in light of the emotional and physical suffering and financial impact of birth defects on society.

SOCIAL AND REHABILITATION SERVICE

Rehabilitation Services Administration

The Rehabilitation Act of 1973 mandates that the vocational rehabilitation program give priority in the provision of services to people who have the most severe physical or mental handicaps. Rehabilitation of the individual with cerebral palsy will be a priority activity, not only because of the severity of the disability itself, but also because of the broad range of handicapping conditions it presents. In virtually every case, a multidisciplinary approach is essential to the development of an appropriate rehabilitation plan for individuals with cerebral palsy. In an effort to expand and intensify rehabilitation services for this disability category, the Rehabilitation Services Administration has utilized several of its grant programs, and some examples of these grant activities are cited below.

A project was supported to operate a special rehabilitation program for severely disabled college students, including those with cerebral palsy, attending the University of California at Berkeley. The grant assisted with the costs of living in a residential unit staffed with professionals to provide the services necessary to maintain the students' health at an optimum level while they were in college. This project was so successful in meeting the needs of these severely disabled students that its activity has now been taken over by the California Department of Rehabilitation as part of its operating program.

Other special projects which have included substantial numbers of people with cerebral palsy in their target populations have been supported by the Rehabilitation Services Administration through grants to the Connecticut Society for Crippled Children and Adults, the Georgia Society for Crippled Children and Adults, and the National Easter Seal Society.

In recent years the Rehabilitation Services Administration has supported short-term training courses in such areas as: (1) vocational rehabilitation methods for professional staff of local affiliates of the United Cerebral Palsy Association; (2) rehabilitation counseling techniques with the cerebral palsied client for the State Rehabilitation agency counselors; and (3) executive development for administrators of cerebral palsy programs.

Number of Rehabilitatants with Cerebral Palsy

Fiscal Year Ending June 30	Persons Rehabilitated	
	Total	Cerebral Palsy
1971	291,272	1,718
1972	326,138	1,771
1973	360,726	1,800
1974	375,000	1,900
1975	394,000	2,300

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DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
PROGRAMS FOR MIGRANT AND OTHER SEASONAL FARMWORKERS

The population of migrant and other seasonal farmworkers in the United States faces a wide variety of problems including low wages and seasonal work, unemployment, limited coverage under labor legislation, lack of job opportunities, low level skills, job displacement caused by increased mechanization of harvesting, undereducation and critical health and housing needs.

At present the Department of Health, Education and Welfare has the responsibility for three programs which are directly targeted to this population. They are as follows:

1. Office of Education, Department of Health, Education, and Welfare (HEW)

    Legislative authority:
    Elementary and Secondary Education Act of 1965, as amended; title I (20 U.S.C. 241b)

    Objective:
    To provide grants to States for programs and projects to meet the special educational needs of children of migratory agricultural workers and to coordinate these programs and projects with similar ones in other States

    Programs:
    Grants to States

2. Office of Child Development, HEW

    Legislative authority:
    Economic Opportunity Act of 1964, as amended; section 222 (42 U.S.C. 2809)

    Objective:
    To expand child-care facilities available to children of migrant families and to develop a network of cooperating grantees to serve these children both while migrating and while they are in their home areas

    Programs:
    Child-care and Head Start programs in 17 States

3. Health Services and Mental Health Administration, HEW

Legislative authority:

Public Health Service Act, as amended on September 25, 1962 (42 U.S.C. 242h), commonly referred to as the Migrant Health Act of 1962

Objective:

To provide grants to public and nonprofit institutions and organizations to finance part of the cost of (1) establishing and operating family service clinics and (2) special projects to improve health services and health conditions for domestic agricultural migratory and seasonal workers

Programs:

Full-time comprehensive health service projects
Part-time comprehensive health service projects
Part-time medical service projects
State-coordinated projects offering direct health services in several counties
Other health service projects

OFFICE OF EDUCATION

REPORT ON MIGRANTS

(Fiscal Year 1975)

Title I of the Elementary and Secondary Education Act, Public Law 89-10, as amended by Public Law 89-750, provides payment to State educational agencies for assistance in educating migratory children of migratory agricultural workers.

Funds are used for programs which are designed to meet the special educational needs of migratory children, and to coordinate these programs and projects with similar programs and projects in other States.

A migrant student record transfer system is located in Little Rock, Arkansas. Teletype terminals are located in 137 strategic areas serving the 48 continental States. This transfer system is funded by an equal percentage of each States' allocation set aside by the U.S. Commissioner of Education. The purpose of the system is to provide to school districts enrolling migratory children rapid transmittal of pertinent general, health and academic data for each migratory child.

This system was developed through the cooperative efforts on behalf of the participating States through the work of an interstate committee. The program direction, specifications for the computer, and the manner by which the system was to be operated was the task given and completed through this cooperation.

Because of the mobile nature of the target population, traditional educational practices needed to be adapted to meet this transitory state of migrant children in an educational environment. Since the inception of the program, States have undertaken this challenge and have developed unique approaches to meet these specific conditions. These efforts have resulted in the earn and learn vocational programs in Florida, New Jersey and North Carolina, in which career awareness and salable skills have been introduced such as supermarket cashiering, assembly line techniques and quality control, automotive tune up, and paramedic training, just to mention a few. These activities provide a small monetary compensation to the migrant student which places relevancy in instructional services acknowledging the economic situation in which the migrant finds himself.

The California Mini-Corps Program was designed to utilize current and former migrant children as tutors and program assistants. It has had a two-fold impact: 1) provides assistance to former migrant pupils in order for them to pursue further educational opportunities in junior colleges and colleges, and 2) provides a model for individualizing instruction to further the educational achievement level of underachieving migrant children.

Since the inception of the program much attention has been focused on the language development of migrant children. These language development efforts have taken the form of bilingual and bicultural instructions, the development of oral language skills, and programs for English as a second language. The migrant program has made a reality of the inservice training of teachers as a basic component of all State activities to facilitate the adequate and efficient delivery of services to migrant children. Because of the mobile nature of the children, cooperation between sending and receiving States is required in order to insure a continuum of educational service. As a result of that challenge the States have cooperated in exchanging teachers, mobile educational facilities, cooperative workshops and conferences, and consultant services.

Currently there are three major interstate program trusts. The States of Minnesota, Wisconsin, Illinois, Indiana, Ohio, and Michigan have formed a consortium of States to cooperatively plan and implement programs in their respective areas. Thirteen western States have assumed a similar responsibility regarding their migrant population. The States on the east coast have already demonstrated their cooperation and concern in interstate efforts by meeting at least annually to share ideas and discuss concerns relating to the east coast migrant stream. In May of 1974, the western States will co-host the 7th Annual National Conference on Migrant Education in California. This conference is initiated, organized and participated in by all the States providing educational services for migrant children.

An estimated 325,000 migrant children were served under this program in 1973. This figure will rise to 380,000 in 1974 and 430,000 in 1975.

Public Law 89-10 ESEA Title III, Supplementary Educational Centers and Services, enables schools to provide programs presently unavailable to children to raise the quality of educational services already offered, and to stimulate the development and evaluation of experimental elementary and secondary education programs to serve as models. Fifteen percent of program funds is mandated for projects serving handicapped children. Other funds are mandated for projects in guidance, counseling and testing.

Originally, the Commissioner made grants directly to local education agencies. Beginning in fiscal year 1971, 85 percent of Title III funds were administered by State educational agencies, with fifteen percent to be used at the Commissioner's discretion within the State.

In fiscal year 1974 a project in Clovis, New Mexico has as its major purpose the development of written curriculum guides for instruction of children who are not proficient in standard English and those who are handicapped. Major target groups are migrant children and multiply handicapped children.

In 1975, the Title I and Title III programs will be included in a new consolicated education grant legislative program.

Title II of the Elementary and Secondary Education Act provides school library resources, textbooks, and other instructional materials for use of children and teachers in public and private elementary and secondary schools.

Delaware, Florida, Georgia, Idaho, Nevada, New Jersey, New York, North Carolina, and South Carolina are among the States reporting the use of Title II funds to provide instructional materials for children of migrant farm workers. Collections of paperback books have been placed in migrant farm labor camps and specialized material purchased for use at school. Pershing County, Nevada reported a Title II project ($1,131) largely concerned with provision of bilingual learning materials for children of migrant labor Spanish-surnamed families. Sunny Ridge School, Nampa, Idaho which serves many children of migrant farm workers reported the expenditure of $1,500 to provide films and filmstrips for five primary school learning centers.

Under the provisions of Title I of the Library Services and Construction Act, a State formula grant program, funds are available for the development of programs designed to provide library services fot the disadvantaged in rural areas and to extend library service to geographical areas and groups of persons without such service. In 1973, at an estimated cost of $102,000, five projects in the five States of Florida, California, New York, New Mexico, and Iowa focused on the library needs of migrant workers and their families.

Two of the types of library services provided specifically for migrants are bookmobile service and library resource center service. Projects in California and Florida illustrate these services.

California - Biblioteca Ambulante, a mobile unit, operates in four counties of central California. Many of the workers served are being exposed for the first time to the free lending library concept. A Spanish language call-in radio program answers questions about the units services which include Spanish written and audio-visual materials. Experience with the Biblioteca Ambulante has stimulated interest in libraries, and many persons are now visiting the main library in Fresno. Florida - A multi-service complex (day care center, health center, educational units) supported by multiple sources of funding has been established to serve the migrant workers and their families in a three county area, including Polk, Hardee and Highlands counties. The library resource center, a part of the complex, and supported by Library Services and Construction Act monies, provides newspapers, books pamphlets, audio-visual materials and equipment. The library resource center serves both recreational and educational needs; for example, the center serves as a tutorial study for adults and students. The main objective of the project is to make the library an integral part of the community life.

In addition to projects specifically designed to serve migrants and their families, migrants benefit from library services provided generally through LSCA projects designed to serve rural low-income areas.

The purpose of the Adult Education Act of 1966, as amended, is to establish and expand programs of adult public education so that adults can continue their education through completion of secondary school and secure job training to help them become more employable, productive and responsible citizens.

Adults 16 years of age and older (including migrants) with less than a 12th grade level of education are eligible for participation in this program. However, many State and local education agencies do not keep records of how many migrants participate in local programs or the amount of funds expended on such participation. Therefore, the estimated amounts represent only those local programs directed specifically toward migrants.

The Vocational education program funds many programs assisting children of migrant workers but there are no attempts to record them as seperate from other children and no accounting for dollars by this category.

OBLIGATIONS FOR PROGRAMS FOR MIGRANTS

	1973 Actual	1974 Estimate	1975 Estimate
Elementary and Secondary Education:			
Educationally deprived children (ESEA, Title I)	$72,722,187	$78,331,437	1/
Supplementary services (ESEA, Title III)	—	128,000	1/
Occupational, Vocational, and Adult Education:			
Adult education - grants to States	1,129,750	1,200,000	1/
Library Resources:			
Public library services (LSCA, Title I)	102,000	170,000	80,000
School library resources (ESEA, Title II)	190,000	200,000	1/
Total, Office of Education	74,143,937	80,029,437	80,000

1/ Federal support for this program is included in a new consolidated education grant legislative program.

OFFICE OF CHILD DEVELOPMENT
INDIAN MIGRANT PROGRAMS DIVISION
Migrant Head Start

OCD/IMPD has, since 1960, had to maintain an extensive effort to mobilize the resources needed to provide full service programs to the families of migrant preschool children. Given that IMPD's funding capability is relatively small in relation to the demonstrated need, one of its imperative goals has been to maximize the utilization of other available resources. The amount of additional resources which have supplemented IMPD funds grew from $880,000 in 1971 to $2,622,837 in 1972 and $2,960,836 in 1973. These figures are significant when compared to IMPD's funding level. In 1973, additional resources provided more than 46% of the total program level.

This increase in resources, coupled with an effective program design, has facilitated an increase in the number of migrant children served from only 620 in 1969 to 7,801 in 1973. The successful increase in participation is due, only in part, to this increase in resources.

Because of the unique needs of migrant farmworking families, programs had to be designed to provide the family with access to these resources without creating economic or other hardships. Resources alone, without an adequate system of delivery, will not solve the problems of migrant families with preschool children.

IMPD has developed and worked with several different program models during the past few years. Some of these models have proven to be less successful than others. But at this stage, none of the models should be totally disregarded. IMPD's findings have shown that in any given area or region, a combination of program models is necessary to meet the existing needs.

All of the models used a basic program design which incorporates Head Start standards and quality child care services. This design calls for some structural modifications to the traditional Head Start program including: (1) extending the hours of operation to coincide with the parents' working hours; (2) allowing all preschool children to participate, including infants, and (3) utilizing bilingual and bicultural staff where needed. These modifications are necessary in order to provide the type of full service program which is tailored to the life style of migrant families.

Basically, there are two catagories of program models, the Local Programs and the National Programs. Local Programs are Head Start programs which are funded to serve local communities, and which may also serve migrant children. There are two types of local program models which serve migrants; the traditional model and the catered model. The traditional model is one which is designed for all the children in the community with no special adaptation for migrant children. This model does not incorporate the structural modifications listed above and is the least desirable of all models. Both the number of children and the number of days each child is in the program are so low that it is doubtful if the program has any lasting impact on the child or the family.

The catered model is one which is designed exclusively or primarily for migrant children. These programs incorporate the three structural modifications and adopt other program features to meet the needs of the target population. This model is more desirable than the common model but it has its limitations. The major limitation is the inability to provide a continuity of program services after the family leaves a particular community. The length of attendance is determined by duration of employment.

Although local programs have at least been able to provide some services to migrant families, generally the long range effectiveness of these efforts is questionable. National programs have been designed not only to meet the unique needs of the target population, but also to guarantee that the length of time a child participates is increased and program continuity is maintained. There are two National Program models; the Prime Grantee model and the Network model.

The Prime Grantee model approached the need to extend the period of services by funding programs in user areas which had longer field work seasons and could operate in one location for four or five months. Families remaining in the area for the entire work season had access to a full service program and the children received educational benefits from having been enrolled for a sufficiently long period. However, this program model did encounter some problems. Most Head Start programs operating in user areas have difficulty in recruiting qualified personnel for two reasons. First, the programs' operating time usually overlaps with the school term and most teachers will accept only summer or full year contracts. Second, there is a lack of qualified personnel who can teach bilingually. Ideally, the staff would share a common primary language with the children but it is almost as difficult to find qualified staff with a secondary language knowledge.

The prime grantee model also attempted to deal with the problem of program continuity. A referral system was devised to refer participants to Head Start programs operating in their home base areas. The child's medical and educational records would also be transferred. Th home base programs, however, are under no obligation to accept referrals and frequently the programs are filled by the time the child returns to the area. Even with these drawbacks, the prime grantee model obviously is a better alternative than either of the two local program models.

The network model differs from the others in that it operates programs in both the home base areas and user states. The program operations follow the migrant streams during the seasons when field work is available and are located in established centers where large concentrations of migrants are found. As the families move from one area to the next the children can be enrolled at the next site. As the target population increases or decreases in a given area, staff members can be regrouped to accommodate the change. This model facilitates recruiting of both staff and participants, provides year-round programs, insures parent participation especially in the off season at the home base site and allows for adequate follow-up. To obtain the maximum benefit from continuing attendance at different sites, it is desirable to have the centers as similar as possible. This is only achieved only with a central administration. Additional advantages of this model include year-round training and career development plans as well as an increase in program quality because of staff continuity from year to year. The network model has generally proven to be the most effective delivery system. It should be stated again that in reality a combination of program models will most effectively meet the needs of migrant farmworker families.

IMPD is fully aware of its responsibility to continue to refine these models and to develop other innovative approaches to guarantee that delivery systems of quality services are provided to the target population. In addition, IMPD recognizes the growing need for an increased effort in program development on behalf of migrants who are attempting to settle out and for seasonal farmworker families.

OFFICE OF CHILD DEVELOPMENT
Migrant Head Start

Obligations for Migrant Head Start Programs

	Actual 1973	Est. 1974	Est. 1975
Head Start Services ...	$3,420,000	$4,000,000	$4,500,000

HEALTH SERVICES ADMINISTRATION
BUREAU OF COMMUNITY HEALTH SERVICES
Migrant Health

Migrant health supports projects to provide health care services to migrant agricultural laborers and seasonal farmworkers and their families in order to improve and maintain the level of their health relative to that of the general population. Services provided range from a full grouping of diagnostic, therapeutic, and follow-up medical services with provisions for dental care, health counseling, preventive and outreach services to a more limited focus on specific diseases.

During the current fiscal period (1974) the Migrant Health Program, administered by the Bureau of Community Health Services, HSA, DHEW, supports 104 migrant health projects. Of this number, 103 provide actual primary ambulatory health care services at sites located in migrant farm workers throughout the United States.

Sixty nine of these projects serve migrants working in low impact areas (areas with less than 6,000 migrants) and 34 provide services in high impact areas (those with more than 6,000 migrants). At the present time, these projects provide the main source of health care services for the nation's 3,000,000 migrant and seasonal agricultural farm workers and their families. Of this number the projects served will have approximately 350,000 patients by June 30, 1974.

Although the current legislation authorizes use of funds for necessary hospitalization, these funds are in fact quite limited. A special demonstration program, designed to provide hospital care effectively and economically for a selected migrant population and to gather and evaluate data on hospital utilization and cost of hospital services, was initiated during fiscal year 1974 at a level of $3 million. The Bureau of Health Insurance, SSA, serves as the fiscal intermediary for reimbursing hospitals for care provided to eligible migrants in this demonstration. Six migrant health projects have initiated programs with nine hospitals to provide access to inpatient care for approximately 50,000 migrants at a fixed daily rate.

Obligations for programs in migrant health

	1971	1972	1973	1974 estimate	1975 estimate
Health services...	$11,525,000	$16,155,000	$22,223,000	$23,750,000	$24,000,000

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